Art Therapy Interventions with an Adolescent with Bipolar Disorder

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Abstract

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Andrea Lefebvre

The current research regarding the usefulness of art therapy interventions with bipolar disordered adolescents is limited. This case study examines the efficacy of art therapy interventions with a 13-year-old African American male client. At the time the case study was conducted, the subject was a client in a residential treatment facility for emotionally and behaviorally troubled adolescents. The results of the case study indicated that art therapy enabled this particular client, who was normally treatment resistant, to cultivate a therapeutic relationship with the art therapist. The client was able to visually explore his thoughts and feelings even when he was unable to verbalize them. The art therapy sessions also allowed the art therapist to identify oncoming cycles of mania through the client’s response to her and the art. The art therapist also discovered that this client became engaged towards therapeutic art tasks that reflected his hobbies and interests.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval Page</td>
<td>ii</td>
</tr>
<tr>
<td>Copyright</td>
<td>iii</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>iv</td>
</tr>
<tr>
<td>Abstract</td>
<td>v</td>
</tr>
<tr>
<td>List of Figures</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter I Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter II Procedures</td>
<td>6</td>
</tr>
<tr>
<td>Chapter III Literature Review</td>
<td>12</td>
</tr>
<tr>
<td>Chapter IV Client’s Description and Background</td>
<td>24</td>
</tr>
<tr>
<td>Chapter V Initial Sessions</td>
<td>29</td>
</tr>
<tr>
<td>Chapter VI Middle Sessions</td>
<td>48</td>
</tr>
<tr>
<td>Chapter VII Final Sessions</td>
<td>69</td>
</tr>
<tr>
<td>Chapter VIII Conclusions and Recommendations</td>
<td>85</td>
</tr>
<tr>
<td>References</td>
<td>92</td>
</tr>
<tr>
<td>Appendixes</td>
<td></td>
</tr>
<tr>
<td>Appendix A: Client Art Therapy</td>
<td>96</td>
</tr>
<tr>
<td>Participation Rubric</td>
<td></td>
</tr>
<tr>
<td>Appendix B: Art Therapy Release Form</td>
<td>97</td>
</tr>
</tbody>
</table>
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chris’ Male and Female Superheroes</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>Tinfoil &amp; Tape Sword</td>
<td>35</td>
</tr>
<tr>
<td>3</td>
<td>Clay Tableau of Chaos</td>
<td>38</td>
</tr>
<tr>
<td>4</td>
<td>Clay People in the Pot</td>
<td>39</td>
</tr>
<tr>
<td>5</td>
<td>Marissa in the Pot</td>
<td>40</td>
</tr>
<tr>
<td>6</td>
<td>Chris’ Painted Mask</td>
<td>45</td>
</tr>
<tr>
<td>7</td>
<td>Chris’ Emotional Hurricane</td>
<td>51</td>
</tr>
<tr>
<td>8</td>
<td>Chris’ Painted Mask</td>
<td>55</td>
</tr>
<tr>
<td>9</td>
<td>Chris’ Ideal Treatment Center</td>
<td>67</td>
</tr>
<tr>
<td>10</td>
<td>Clay Log</td>
<td>75</td>
</tr>
<tr>
<td>11</td>
<td>Happy Birthday Sign</td>
<td>78</td>
</tr>
<tr>
<td>12</td>
<td>The Gift</td>
<td>79</td>
</tr>
<tr>
<td>13</td>
<td>Chris’ Sprout</td>
<td>81</td>
</tr>
<tr>
<td>14</td>
<td>Chris’ Second Super Hero</td>
<td>82</td>
</tr>
</tbody>
</table>
Chapter I

Introduction

“I don’t wanna go to therapy”, the boy complained, “Damn, leave me alone!” As he said this, the boy’s thumbs never stopped moving over his GameBoy. “Why are you always bugging me with this therapy sh_ t!” The therapist takes a quick look at her watch and thinks, “Why must we go through this before each session? It never fails, this client will complain bitterly about attending therapy, but then profess to have a wonderful time by the end of the session.” The therapist kneels down to where the client is sitting and asks, “Well, you said last session that you had a good time. And if memory serves, you were awfully bummed when the session ended.” The boy reluctantly nods his head in agreement and looks up from his GameBoy. “Yeah, I had a good time; but I don’t want to go now, ok?” He turns his attention back to the video game. The therapist calmly stands up and turns to go. The boy angrily looks up from his game, “Where are you going? I thought we had therapy?”

Statement of the Problem

Counseling adolescent clients can be a tricky and frustrating business. Getting an adolescent client to willingly participate in an individual or group therapy intervention is a challenge for even the most seasoned therapists (Lambie, 2004; Scales, 2005). The adolescent client often appears hostile, defiant, and poorly motivated for behavioral change (Lambie, 2004). Therefore, what can a therapist do to engage and motivate adolescent clients in a residential treatment environment?
Purpose of the Study

In an effort to find effective therapeutic interventions for adolescents in individual therapy, the purpose of this project was to use art therapy interventions to motivate and engage an adolescent client at a residential psychiatric treatment facility. The efficacy of the therapeutic interventions was defined by how well the activities engaged the adolescent client and promoted a therapeutic dialogue with the therapist.

Research Questions

The central research question explored during the course of the study was: In what ways did art therapy interventions encourage an adolescent client’s level of participation in the therapy? Sub-questions explored during the course of the study included: What art therapy interventions were effective with an adolescent client, what art therapy interventions were not effective with an adolescent client, and did the art therapy interventions enhance the therapeutic dialogue between the therapist and the client.

Definition of Terms

Art therapy - model of therapy that believes the creative process of art making is healing and life enhancing and is a form of nonverbal communication of thoughts and feelings (Tyson & Bafflour, 2004).

Art therapy technique - “a concrete implementation of theory introduced by the art therapist at the appropriate time to facilitate creative and therapeutic change” (Robbins, 2002, p. 50).
Bipolar Disorder – a mood disorder characterized, per the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), by the “occurrences of one or more Manic Episodes… or Mixed Episodes…Often individuals have also had one or more Major Depressive Episodes” (American Psychiatric Association, 2000, p. 382).

Case manager – refers to the person who coordinates an individual client’s services while at the residential treatment facility. This individual writes the client’s treatment plan, regularly meets with the client to discuss his needs (e.g. clothing vouchers, medical appointments, family concerns), and serves as the client’s advocate by ensuring he is receiving the necessary services in the residential treatment facility.

Clients- refers to adolescents who receive services at the residential treatment facility. Often these adolescents live at the residential treatment facility.

Client engagement- positive involvement, by client, in the interventions and with the therapist during the therapy session.

Cottage- In residential psychiatric treatment facilities, particularly those with long-term residents, client-housing facilities consist of multiple dormitories often called “cottages”. These buildings usually contain a dining area, living room area, staff office, kitchen, several schoolrooms and client bedrooms. Depending on a client’s circumstances and the occupancy rate, he/she may share a bedroom or have a single bedroom. Each cottage is manned by a collection of therapists, childcare workers, kitchen staff, and nurses.
Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) – is “a categorical classification guide that divides disorders into types based on criteria sets with defining features” (American Psychiatric Association, 2000, p. xxx).

**Group therapy**- a therapy group usually has a specific focus, which may be educational, psychological, behavioral, or social. Members of the same therapy group usually have similar psychological issues and treatment goals.

**High functioning client**-individual with average to above average cognitive abilities and ability to use appropriate coping skills when upset.

**Internal Service Plan** (ISP)- refers to a client’s individual treatment plan. It is composed of measurable treatment goals. A designated member(s) of a client’s treatment team (e.g. group therapist, individual therapist, psychiatrist, and case manager) oversees each treatment goal.

**Low functioning client**- an individual with below average cognitive abilities, who struggles to use appropriate coping skills when upset. Usually this client acts out (e.g. hits, throws items, screams, or swears) when angry or hurt.

**Partial hospitalization service** (PH group) – refers to an intensive, structured, goal oriented, distinct, and identifiable scheduled program that consists of high levels of face-to-face mental health interventions that address the individual mental health needs of the individual as identified in his treatment plan. This type of program must last a minimum of 3 hours per day. At the residential facility where the research took place, partial hospitalization programming took place every afternoon, seven days a week for three hours per day.
Delimitations and Limitations

The delimitations of this case study were that it confined itself to interviewing and observing one adolescent client, who was receiving treatment in a Midwest residential psychiatric facility, and who was in therapy sessions facilitated by the researcher.

One of the limitations of the study was that the researcher’s ethnic and socio-economic background was quite different from the research participant. As a result, communication between the therapist and the client was sometimes misinterpreted. Another limitation was that the researcher’s role as an assistant cottage supervisor in the participant’s cottage affected his involvement in therapy.
Chapter II.

Procedures

Characteristics of Qualitative Research

Qualitative research is characterized by data collection within a natural setting; thus, the researcher goes to the site (home or school) of the participants. The researcher looks for involvement by clients in collecting data and seeks to build rapport with them (Creswell, 2003). Furthermore, qualitative research focuses on the process rather than specifying an outcome.

Qualitative researchers believe the reality of the situation or problem being studied is a complex mix of interwoven variables that are difficult to measure. These types of studies focus on themes or patterns versus causality or predictions (Campbell, 1997).

Qualitative Research Strategy

Due to the limited amount of research available regarding effective art therapy interventions and adolescent therapy, the knowledge claims for this research project were generated within a constructivist framework. Rather than introduce a theory to be tested, based on antecedent claims, theories were generated from the data collected in the field (Creswell, 2003).

The strategy of inquiry chosen for this research project was a case study approach. The central phenomenon being studied, the efficacy of art therapy interventions with adolescents was well suited for a case study approach because it was bounded by time and activity (Creswell, 2003).
**Role of the Researcher**

For seven months, I worked as an art therapy intern at the research site. In addition, I concurrently worked as an assistant cottage supervisor in the client’s cottage, at the research facility.

In order to conduct research at this particular site, I obtained permission from the director of partial hospitalization services and group behavioral health counseling, the director of expressive arts counseling, and the agency’s legal representative.

**Data Collection Procedures**

**Setting.** The case study took place in a midwestern residential psychiatric treatment facility for adolescents. It consisted of three cottages (i.e. client residences), an onsite school, and partial hospitalization group therapy building (the PH building).

The art therapy sessions study took place in three locations: a group therapy room within the same building as the client’s cottage, my office in the client’s cottage, and in a room in the PH building. The group therapy room, located in the same building as the client’s cottage, was located down the hall from the client’s cottage. It was a small windowless room painted a dull beige color. Florescent lights were tucked into industrial ceiling tiles. Two long brown collapsible tables filled most of the room. A mismatched assortment of plastic chairs surrounded the tables. Two gray metal filing cabinets lined one of the walls, and industrial blue carpet covered the floor. Crumpled coloring sheets, empty water bottles, and broken
colored pencils usually littered the tables. My office, where some sessions occurred was located off the main living area of the client’s cottage. A heavy wooden door separated my office from the rest of the cottage. Although the office was small, it was brightly lit. Two large windows lined two of the office’s walls and an overhead fluorescent light flooded the small space. Two desks with matching desktop computers faced one another on opposite walls. Although there were two desks, only I worked out of this space. Near my desk was a padded swiveling chair and a molded plastic chair sat near the unused desk. Some of the sessions were also conducted in the PH building. It was an old two-story brick structure located next door to the client’s cottage. All of the doors and windows in the PH building were locked and staff members used a key to enter or exit. The lower level of the building consisted solely of two large group therapy rooms and a half bathroom. The upstairs of the PH building was off limits to clients. Both of the group therapy rooms were both painted blue, and were well lit. The rooms both had one wall lined with large picture windows covered in Plexiglas. Collapsible tables and plastic molded chairs filled each room.

Participant. For the purpose of this research project, one client was studied in depth. He was a 14-year-old African American male with a diagnosis of Bipolar Disorder. The case study participant was selected for this case study by the researcher and his case manager. Participant selection criteria were based upon the client’s treatment goals, level of functioning and personal interests.
Methods of Gathering Data

Data for this research project was collected through field observations, client interviews, and the art pieces the client created during the therapy sessions. I conducted individual therapy sessions with the client and used an observational rubric for recording observational data (see Appendix A). Furthermore, I routinely communicated with client’s individual therapist, group therapists, psychiatrist and case manager regarding his treatment progress and maintained a communication log regarding these conversations. Finally, the client’s artwork produced during the therapy sessions was collected and photographed for coding purposes.

Data Analysis Procedures

I organized the data, gathered through the observational rubric forms, the communication logs, and the images from the art pieces, into themes. Finally, I interpreted the data and discovered more questions to be raised for future study (Creswell, 2003).

Strategies for Validating Findings

Different data sources of information (e.g. the client’s individual therapist and case manager) were used to validate observational data. I incorporated information from peer debriefing, the research site’s expressive arts director, the client’s case manager, the childcare workers from his cottage, and the partial hospitalization/group behavioral health director. Additionally, themes emerging from the client’s artwork were compared with current art therapy theories and literature.
Narrative Structure

The narrative approach for this research project offered an analysis of the case. Scripted conversations from the individual therapy sessions were included, with words oftentimes spelled out phonetically to reflect the participant’s cultural background and the flavor of the setting. Quotes of varying lengths were included to further the narrative or to emphasize an emerging theme. Within the narrative, themes and ideas posited by the researcher will be compared to the current literature on adolescent therapy and adolescent art therapy. A description of the sessions and the client’s artwork will be provided.

Anticipated Ethical Issues

The research objectives were verbally articulated so they were clearly understood by the client. I had the client fill out a written permission form before the study began (see Appendix B). The client’s name and identifying details were altered to ensure his anonymity. The same anonymity was given to the research site and its staff members. All clients and staff mentioned throughout the thesis will be given pseudonyms. Additionally, the client was informed as to how the data collected would be disseminated. I also obtained permission from the client’s legal guardian via consent forms (see Appendix B).

Significance of the Study

This constructivist case study sought to discover if art therapy was an effective therapy modality with an adolescent in individual therapy. It is intended to expand the current art therapy literature with adolescents and add to the limited
research regarding this subject. Through this case study, I hoped to identify which art therapy interventions engaged my adolescent client and to gain insight as to why they worked. Furthermore, if an art therapy intervention did not engage the client, I wanted to examine why that was the case. Finally, I intended to examine if art therapy interventions enhanced the therapeutic dialogue between the therapist and the client and why this occurred.

Expected Outcomes

From the research conducted, I expect to uncover effective art therapy interventions for an adolescent client. I also anticipated that some art therapy sessions used during the sessions would not be engaging or would only partially engage the client. Because my client had a history of refusing therapy or leaving sessions early, I expected him to act the same way during my sessions. I hoped that the art therapy interventions would be engaging enough to this client, so that his likelihood of refusing art therapy or leaving early would be less.
Chapter III
Literature Review

Introduction

The literature review will be divided into three different sections. In the first section, the current research regarding bipolar disorder symptomology, differential diagnosis of the disorder, and treatment of bipolar in adolescents will be examined. Within the second section, the current literature regarding adolescents’ attitudes toward counseling will be explored. Finally, literature regarding adolescent client’s receptiveness towards art therapy will be discussed.

Adolescents and Bipolar Disorder

Over the last several years, there has been a growing body of published research focused on identifying the characteristics of early onset bipolar disorder (EOSBD) (McIntosh & Trotter, 2006; Biederman, Kwon, Wozniak, Mick, Markowitz, Fazio, & Faraone, 2004; Wilkinson, Taylor, & Holt, 2002; Giles, DeBello, Stanford, & Strakowski, 2007). While this research has increased the understanding of EOSBD, researchers are still struggling to tease out what behaviors are indicative of this illness and not overlapping symptoms of other adolescent or childhood disorders (McIntosh & Trotter, 2006; Blader & Carlson, 2007; Wilkinson et al., 2002).

Manic symptoms, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), are defined as: inflated self esteem, decreased need for sleep, flight of ideas, pressured speech, increase in goal directed activity,
distractibility, increased risk taking behavior (2000). In place of the euphoria (i.e. inflated self esteem, decreased need for sleep, flight of ideas etc.) seen in adult cases, adolescent mania commonly manifests itself as irritability, physical destructiveness, and violent rages (McIntosh & Trotter, 2006; Wilkinson et al., 2002). Often the symptoms are debilitating and lead to hospitalization. Adolescents with Bipolar II Disorder have at least one major depressive episode and at least one 24-hour period of hypomanic thoughts and behaviors (American Psychiatric Association, 2000). Depression, per the DSM-IV-TR, is characterized as: depressed mood, decreased interest in hobbies and activities, weight gain/weight loss, sleeplessness, loss of energy, inability to concentrate, feelings of worthlessness, and/or suicidal ideation (2000). Depression in bipolar adolescents does not always appear as lethargy, sad affect or worthlessness. Adolescents with EOSBD often act impulsively when they feel depressed in order to feel more energetic. Hypomanic symptomology, seen in Bipolar II Disorder, is nearly identical to manic symptoms, but they are not as debilitating (Web et al., 2005).

The criteria for diagnosing EOSBD in adolescents are the same as those for adults. Bipolar Disorders are divided into two types: Bipolar I Disorder and Bipolar II Disorder (American Psychiatric Association, 2000). The main difference between the two types of the disorder is that Bipolar I Disorder is characterized by the person have at least one manic episode (defined as a minimum of four consecutive days of manic symptoms), though there may or may not be subsequent bouts of depression.
The differential diagnosis between EOSBD and another disorder, attention deficit/hyperactivity disorder (ADHD), can be difficult due to the overlap in symptomology (Wilkinson et al., 2002; McIntosh & Trotter, 2006). Manic symptoms such as irritability, distractibility, and impulsivity may mimic those of ADHD. However, a mental status exam and a thorough patient history enable a clinician to differentiate between the two disorders. Temper tantrums and physical aggression, often seen in both disorders, are triggered by emotional and sensory stimulation in an ADHD client, but are elicited by adult limit setting in those with EOSBD (McIntosh & Trotter, 2006). Diagnostic confusion also exists because of the similarity that exists between EOSBD and conduct disorder (CD). Both disorders are associated with hypersexual behavior, angry outbursts, antisocial behavior, and substance abuse. Again, a detailed patient history enables a clinician to differentiate between the two disorders (McIntosh & Trotter, 2006). The sudden onset of behavioral problems may indicate EOSBD, whereas with CD the presence of problematic behaviors is apparent over many years. Furthermore, a conduct-disordered adolescent does not have the pressured speech or flight of ideas as an individual with bipolar disorder. Additionally, mischievousness and playfulness not vindictiveness distinguish bipolar disorder from conduct disorder (McIntosh & Trotter, 2006; Wilkinson et al., 2002).

As with adult bipolar disorder, psychopharmacological treatment is considered the first line of treatment for EOSBD (Wilkinson et al., 2002; Foltz, 2006; McIntosh & Trotter, 2006); however the efficacy of the medications used to
treat adolescents is still debatable (McIntosh & Trotter, 2006). This is due to the lack of studies using adolescents and children as subjects. Researchers are discovering that a various combinations of mood stabilizers, stimulants, and antipsychotics are proving effective in the management of adolescent bipolar disorder (Wilkinson et al., 2002; Preston, O’Neal, & Talaga, 2004; McIntosh & Trotter, 2006).

According to McIntosh & Trotter, psychoeducational treatment is also becoming an increasingly popular method of educating the parents and teachers of adolescents with EOSBD (2006). One of the goals with this type of treatment is to enable parents and teachers to recognize the biological origins behind the mood shifts and be more likely to respond with empathy and understanding. Another goal of this treatment is to give parents and teachers the problem solving skills necessary to handle their child’s outbursts, redirect the negative behaviors and positively affect emotional regulation in the child (McIntosh & Trotter, 2006).

There is a lack of published research with regards to effective psychological interventions for EOSBD (McIntosh & Trotter, 2006; Wilkinson et al., 2002). Practitioners in the field and researchers have largely relied on the literature surrounding therapeutic interventions for adult bipolar disorder. However, there are a few therapeutic approaches, used with adults that now appear promising in the treatment of EOSBD. These therapy approaches include: cognitive, cognitive behavioral and schema-focused therapies (Vieta and Colom, 2004; Tripp & McMahon, 2007). In addition, a recently published study by Goldstein, Axelson,
Birmaher, & Brent suggests that dialectical behavior therapy (DBT) holds a great deal of promise in the treatment of adolescent bipolar disorder (2007).

Researchers and clinicians are coming to realize that the developmental psychology, neurochemistry, and physiology are different in adolescents versus adults. Naturally, therapies that prove useful in adults will not have parallel results in adolescents. Therefore, more research is necessary in order to determine what are effective therapeutic interventions specifically with bipolar adolescents (Foltz, 2006). In the next section, the research regarding adolescent’s attitudes towards various counseling interventions and therapists will be explored.  

*Young Adolescents and Counseling*

Much research has been generated regarding counseling expectations in late adolescents and adults. According to Barich, the research has been connected to the assumption that clients’ expectations can either positively or negatively impact important aspects of counseling, including the client’s decision to remain in counseling, what concerns are addressed during counseling sessions, and the quality of the therapeutic alliance between client and counselor (2002). Very little research has been published around the attitudes and expectations of middle school adolescents towards counseling (Moore-Thomas & Lent, 2007; Barich, 2002). According to a recent study by Moore-Thomas & Lent, middle school aged clients are more sensitive to the power dynamics between themselves and their therapist than older clients (2007). In essence, younger adolescents would be more inclined to ask, “What will I need to do?” versus “What will the counselor do for me?”
Moore-Thomas & Lent also found gender differences in middle school aged clients’ attitudes toward seeking out counseling help (2007). These differences, not surprisingly, reflect the gender role socialization processes that are so clearly defined during middle school. Girls, at that age, are encouraged to solve their problems socially and would be more likely to seek out the aid of a counselor. Therefore, middle school aged girls have higher expectations from themselves and their counselors with regards to the counseling process (Moore-Thomas & Lent, 2007). Middle school aged boys were found to have lower expectations from the counseling process. Additionally, a study on male adolescent’s views on mental health counseling suggested that this particular population associated it with mental illness and pathology—not mental health promotion (Smith, 2007). Although the majority of the research participants in this study reported never using mental health counseling, over half said they would attend counseling for life concerns. Moore-Thomas & Lent suggested that counselors working with middle school aged boys should take additional steps to promote positive but realistic expectations regarding the counseling process with their clients (2007). Smith’s research also reported that some of male adolescents identified the use of games, sports, exercise, or some multimedia activities as conducive to a successful counseling experience (2007). The distraction of an action-oriented or recreational activity perhaps allows male adolescents to feel less anxious in sharing their concerns with a therapist.

Another important aspect of counseling adolescents is the therapeutic relationship developed between the middle school aged client and the therapist. A
recent study by Martin, Romas, Medford, Leffert, & Hatcher identified adolescents’ preferred adult qualities in helping relationships with adults (2006). According to the study, the top three adult qualities preferred by adolescent clients were: the adult’s openness to the client’s ideas, adult demonstrations of respect towards the adolescent client, and time shared (including the notion that the adult enjoys spending time with the client). In addition, the study revealed that adolescent clients want to be viewed by their therapists as mature, capable, and self-aware. Finally, the adolescents wanted adults to empathetically support and guide them (Martin et al., 2006).

In addition to the preferred adult helping qualities mentioned above, a study by Hall, Gutterman, Lee, & Little discovered another set of variables that improved treatment outcomes with children and adolescents: counselor-client matching on language, ethnicity, and gender (2002). Specifically, treatment outcomes in matched client-therapist dyads were considerably higher than non-matched dyads.

There have been many published studies regarding the efficacy of various psychotherapy approaches with adolescents for a variety of mental disorders and illnesses. Many of these approaches apply principles from cognitive behavioral therapy, psychoeducational approaches and psychodynamic therapies (Larmar, 2005; McIntosh & Trotter, 2006; Tripp, Vernon, & McMahon, 2007; Foltz, 2006). A review of the literature on the use of various therapy modalities with the adolescents does not single out one particular approach as a panacea with this population. The current research suggests that the relationship between the therapist and the client
has the most impact on the treatment outcome, regardless of the modality used (Martin et al., 2006; Smith, 2004; Hall et al., 2002; Utsey, Howard, Williams, 2003).

Individual and group therapy approaches, according to the current literature, were both useful when working adolescent clients (Larmar, 2006, Martin et al., 2006; Smith, 2004; Hall et al., 2002; Utsey, Howard, Williams, 2003). Individual counseling can be effective when a client needs to deal with a variety of personal struggles and issues.

However, a major area of concern for most adolescents is their relationships with peers and learning how to function in groups outside their family. Having a mood or anxiety disorder certainly can impact how an adolescent functions within their circle of peers (Goldstein et al., 2007; Hlastala & Frank, 2006; Larmar, 2006; Martin et al., 2006). Therefore, group therapy provides a safe space for developing appropriate social skills, learning how to deal with conflict in a healthy manner, and collaborating with peers who are struggling with similar issues.

*Adolescents and Art Therapy*

According to the American Art Therapy Association (2007), art therapy is based on the idea that the creative process of art making is healing and is a form of nonverbal communication of thoughts and feelings. Two different approaches within this therapeutic modality are used: art psychotherapy and art as therapy. According to art therapist Bruce Moon, art psychotherapy is an approach to art therapy in which the process of making art is a tool used to facilitate verbal expression and insight (1998). Another approach used in art therapy is the art as therapy model. With this
approach, verbalization and conscious articulation of insight regarding art making may or may not occur (Moon, 1998).

A review of the literature indicates there is very little current published research with regards to adolescents and art therapy. During the end of the last millennium, a wave of art therapy literature appeared in various academic psychological and counseling journals. Then the wave slowed to a trickle. This seems surprising, in light of the proliferation of research regarding adolescent mental disorders, such as ADHD, bipolar, anxiety disorders (McIntosh & Trotter, 2006; Tripp & McMahon, 2007; Foltz, 2006; Larmar, 2006). Developmentally, art therapy seems tailor-made for adolescent clients. Well-respected art therapists Shirley Riley and Cathy Malchiodi (2002) have both said, that creativity is a dominant trait of adolescence. Along that same vein, “art therapy is a modality based on the notion that when creativity is introduced into problem solving, the art can provide fresh viewpoints and excitement” (Riley, 2002, p. 38).

Current literature on art therapy suggests that this modality often appeals to adolescents because it enables them to control the flow of communication. This plays into a key theme adolescents seem to struggle with: the need for autonomy. The adolescent can create whatever she/he wants with the art materials and share verbally what she/he wishes (Riley, 2003; Malchiodi, 2003). Allowing the adolescent to control the flow of conversation, according to Riley, helps establish an early alliance between the therapist and the adolescent client. As mentioned previously, the success or failure of a treatment outcome, with the adolescent client,
is largely determined by his/her relationship with the therapist (Martin et al., 2006; Smith, 2004; Hall et al., 2002; Utsey, Howard, Williams, 2003).

A promising study, by Tyson & Baffour, used a solution-focused approach to art therapy with adolescents in an acute-care psychiatric setting (2004). In solution-focused art therapy, the therapeutic relationship begins with mutual goal setting, in order to decrease client resistance. The therapist and client become co-creators and partners in problem solving. This approach would appeal to an adolescent, because it offers them the autonomy and support they crave from a therapist (Martin et al., 2006; Riley & Malchiodi, 2003). Tyson & Baffour (2004) discovered that by using a solution-focused therapeutic technique, the adolescent clients self-identified a variety of arts-based strengths (e.g. writing poetry, singing, dancing, or drawing). The researchers found that their subjects used these arts-based strengths as coping methods when struggling with difficult situations. By supporting the client’s creative intelligence for using art as a coping skill, “therapists not only encourage this practice, but also affirm the value and worth of clients as [individuals]” (Tyson & Baffour, 2004).

Another way art therapy works effectively for the adolescent population is that the therapeutic process is action based. Art making, whether it is singing, painting, sculpting or dancing expends energy. As mentioned earlier, adolescents, particularly boys, prefer to engage in activity during a therapy session (Smith, 2004). Furthermore, adolescent mental disorders, particularly depression, CD, bipolar and ADHD, often present as physical aggression or acting out (DSM-IV-TR). Art making
during a therapy session gives the adolescent client the physical energy outlet they need. As Riley stated, “art is the one action that can be used therapeutically and can be conformed to the needs of the adolescent client” (2003).

Finally, no literature review of adolescent art therapy is complete without a mention of Bruce Moon’s work with this population. His work provides valuable insight into the process of working with adolescent clients (1998). According to Moon, there are four phases of adolescent art therapy 1) resistance, 2) imagining, 3) immersion, and 4) letting go (1998). Adolescents initially view the art therapist and the structure of the arts studio “as foes who must be conquered”; and Moon insists it’s a phase that should be addressed by the art therapist (1998). The second imagining phase has three distinct aspects 1) the denial of disturbing behavior and feelings is gradually abandoned, 2) a solid relationship based on trust and mutual engagement in art making is established, 3) a healthy vision of how the adolescent imagines his/her future begins to emerge (Moon, 1998). The third phase, immersion, according to Moon (1998), occurs when the adolescent patient is able to connect to his/her own inner experiences, and establish ownership for present emotional and behavioral difficulties. Finally, the letting go phase is more a process than an event (Moon, 1998). During this period, the adolescent client internalizes and consolidates the gains made during the treatment process (Moon, 1998). In addition to the four phases of adolescent art therapy; Moon highlighted six themes commonly seen in the pieces created by adolescents in art therapy: identity confusion, risk-taking, suicidality, self-loathing, intense anger, and fear of abandonment (1998). Moon
explains that it is crucial for the art therapist to know that he/she can deal with the ugly ruined parts of our adolescent clients by knowing and accepting that these parts can be changed by art (1998). “Making art can help to solidify identity, encourage acceptable risks, lessen suicidality, transform self-loathing, soothe anger, and ease abandonment fear” (Moon, 1998, p. 172).

Art therapy seems tailor made for adolescent clients in that it offers them the autonomy they crave, builds on their natural creative tendencies, and expends physical energy.
Chapter IV

Client’s Description and Background

Description of the client

The client, Chris (a pseudonym) was a fourteen-year-old African American male with a rangy build, large brown eyes, and a wide bright smile. He had a thick brown Afro that was a magnet for cotton fuzz and dust bunnies. He often appeared unkempt in wrinkled t-shirts, stained sweatshirts, and torn jeans.

Chris’ general affect was labile--ranging from smiling and laughing one minute to angry and cursing the next. When Chris was in a good mood, he was energetic, playful, affectionate, and funny. If, however, Chris was angry or upset, he was irritable, violent, and verbally abusive. Chris was also easily bored, and was always seeking new forms of stimulation. He enjoyed working with his hands and his preferred methods of stimulation were: playing with his GameBoy, building things with Legos, or shadow boxing with other clients or a (unwilling) staff member.

Reason for admission

Prior to arriving at the current residential treatment center, where the case study occurred, Chris was at another treatment center for a 30-day assessment. Before Chris was admitted to either residential treatment center, he was removed from four separate foster homes due to manic-like behaviors and destroying property in the homes. Ultimately, Chris was admitted to the current residential treatment center because he required close monitoring to gauge the effectiveness of the
medications for his diagnosed bipolar disorder. In addition, Chris required intensive counseling to address his history of abuse, severe neglect, and evaluation for a possible foster placement.

**Diagnoses**

Chris’s past diagnosis included ADHD, depression, attachment disorder, mood disorder, psychosis, and post traumatic stress disorder. Ultimately, his treatment team at the current treatment center settled on the following diagnosis:

**Axis I** Bipolar I Disorder

**Axis II** No diagnosis

**Axis III** Asthma

**Axis IV** Problems with primary support group (removed from last foster home)

Social problems (oppositional behaviors and problems with peers)

**Axis V** Global Assessment of Functioning Score 50

**Psychological Evaluation**

Per a mental health assessment administered by his therapist, Chris presented with pressured speech and was prone to angry outbursts. Chris had a history of aggression towards his teachers and peers. He appeared anxious, had grandiose thoughts, and a rapid flight of ideas. Chris had a history of inappropriate sexual behaviors (e.g. rubbing his genitals against furniture). Additionally, he had a history of visual and auditory hallucinations. Chris also admitted to infrequent suicidal ideation and self-mutilative urges. Also, he was found to have depressive symptoms, such as a sense of worthlessness, guilt, and, self-directed anger.
Chris’ cognitive ability was found to be average with a full scale IQ of 98. His verbal abilities were especially strong, for Chris was articulate, insightful, and could read well. School records indicated that Chris was in 7th grade, but worked below his ability level. Chris had no other learning barriers (e.g. processing deficits) but was placed in special education classes, namely severely behaviorally handicapped (SBH) classes due to his disruptive behaviors.

*Psychiatric Evaluation*

An overview of Chris’ psychiatric notes indicated that his psychiatrist, at his current residential treatment facility, found him to be anxious, hyper, irritable, and sexually inappropriate. The psychiatrist routinely pointed out that the behaviors exhibited by Chris were consistent with those of Bipolar I Disorder. Although the psychiatrist was unwavering in her diagnosis, she frequently added, decreased or changed Chris’ medications prescribing various combinations of mood stabilizers, antipsychotics, antidepressants, and psycho-stimulants. Chris’ psychiatric notes indicated that he had no adverse side effects to these medications.

*Family History*

According to the client’s records, Chris lived with his relatives, siblings, and his biological mother in a city several hours away from the residential treatment center until he was 10 years old. His biological father reportedly had died from a gunshot wound. Chris’ biological mother had a history of substance abuse and a variety of mental health concerns. It was unknown whether there were any prenatal or developmental concerns when Chris was an infant or a toddler. Chris had a
number of brothers and sisters. He and his siblings experienced a great deal of severe neglect and abuse while living with their biological mother. At one point, Chris’ brother prostituted their sister for food. The conditions in Chris’ home were so bad, that he recalled waking up and having cockroaches climbing on his body. In addition, there was suspected sexual abuse within this home. Ultimately, it was Chris, who “blew the whistle” on his biological mother and the relatives regarding the abuse and neglect he and his siblings endured. All the children were removed from the home and custody was taken away from the biological mom and awarded to the local county department of child and family services. All of Chris’ siblings had little difficulty transitioning into other foster families. Unfortunately, Chris was not so fortunate.

**Personal History**

Upon removal from his biological mother’s home, Chris lived in a number of foster homes. He was removed from all of those foster families due to his manic behavior, violent behaviors, and property destruction within each of the homes. While in one of the foster homes, Chris killed a squirrel in front of several other children. Furthermore, Chris’ aggressive behavior made it difficult for him to maintain friendships. When Chris was 13 years old, his social worker placed him in a residential treatment facility for a 30-day mental health assessment.

While at the treatment facility, Chris was in therapeutic restraints four separate times for assaulting staff. Reports indicated that Chris did not tolerate group therapy and had a lot of difficulty using any therapies. Chris routinely avoided
any attempt at addressing his problematic behaviors or abuse history. Furthermore, Chris denied sexual victimization even though he had disclosed that another foster child attempted to sexually assault him. When asked to participate in therapy, at both residential treatment facilities, Chris often acted out with aggression or made sexually provocative comments. His therapists and psychiatrists at both treatment facilities commented that this behavior appeared to be Chris’ way of avoiding any attempts at dealing with his treatment issues.

Chris’ case manager, Casey (a pseudonym), at his current residential setting, requested that he receive individualized art therapy as an adjunct to his group therapy and talk therapy routine. According to Casey, Chris would regularly refuse to attend his individual therapy and group therapy sessions. When he did attend a therapy session (group or individual), Chris became verbally and/or physically aggressive to the therapists and other clients. In place of attending therapy, Chris would play with his Lego bricks for hours or draw cartoon characters in a sketchpad. Casey believed that art therapy would allow Chris to explore his emotions in a manner that suited his creative nature. Casey and I ran the idea of individualized art therapy sessions past Chris and he committed to trying at least one session. One session was all it took to get Chris to remain in individualized art therapy for the rest of his stay in this residential treatment program. The following chapters detail Chris’ progress in individualized art therapy. Unlike his individual talk therapy and group therapy sessions, Chris rarely refused to individualized art therapy sessions with “Miss Andrea” (as I came to be known).
Chapter V

Initial Sessions

Session 1: Draw a Superhero

As mentioned in the previous chapter, Chris was, historically, resistant to both group and individual therapy; however, his treatment team thought, due to his strong interest in drawing (and all things creative), art therapy might break through his defenses. During my initial meeting with Chris, I had several goals in mind: 1) develop our therapeutic relationship, 2) gain better understanding of Chris, 3) engage Chris enough so that he would want to continue with art therapy. When I initially met Chris, we agreed to conduct our sessions after dinnertime on Monday nights, the one evening a week he did not have group therapy. Having Chris follow a structured schedule was an important part of his treatment plan. I chose to hold our first session in a group therapy room down the hall from Chris’ cottage, so a staff member would be nearby if Chris’ behavior got out of hand. Having never been alone with Chris, I did not know how he would behave. He had a history of disruptive behavior in group therapy and was reportedly violent toward staff members from time to time.

The first session got off to a rough start. Chris claimed to have forgotten we were starting art therapy that week and appeared angry with me for pulling him away from his Legos. Initially, Chris refused therapy, but after a bit of cajoling on the part of his case manager, reluctantly agreed to attend. When Chris entered the therapy room, he appeared to bristle with anger, and paced the room like a caged animal as we began our session.
“This session won’t last long. I just want to spend this time getting to know you better, and also letting you know what art therapy is and isn’t”, I began.

Chris nodded and continued to pace. “Are you going to teach me to draw? Can we bring my Legos to sessions and build things? That’s art. Building is an art—I mean there is an artistic side to everything. Cooking is an art. Someone could plant a garden well and that’s art…” Chris’ words came out in a spray of ideas.

“Ok, slow down. Sure we can build things”, I assured him, “but one thing at a time.”

Chris and I came up with a list of session rules and expectations. There were the basic rules regarding timeliness, respect (on both our parts), and confidentiality. Chris, despite his history of poor treatment compliance, showed terrific insight into his behavior and needs, “Miss Andrea, there will be times when I feel myself getting out of control and wanting to wild out, ok. When I do, just take me back to my room and let me settle down for a bit. Once I’ve calmed down, I’ll be ready to work again.”

I was startled by his insight and agreed to this request. Chris and I then moved on to the art-making portion of the session. Chris was given a pencil and a selection of different sizes of white paper (e.g. 8½” x 11” sheets and 18” x 24” sheets). He was then instructed to “draw a superhero” (Figure 1). Chris stopped pacing, smiled broadly, and quickly sat down to work. Taking up one of the larger sheets up paper, Chris labored over his drawing for ten minutes. Throughout his art making process, Chris apologized for his lack of skill say, “I’m usually better than
this. This isn’t my best work.” When he finished the drawing, I asked Chris, “Is this superhero male or female?” To which he quickly replied, “Male.” Chris was then instructed to draw a female superhero, and this directive momentarily stumped him. Chris frowned, but then, like the sun appearing from behind a cloud, out came his bright smile. “OH! I know what I’ll do”, Chris exclaimed.

On the same sheet of paper, right next to the first superhero, Chris created a similar, albeit less detailed, individual. “See, she”, Chris said proudly pointing at his drawing, “is wearing a bow!”

Chris was then asked to describe his drawings. He studied both drawings for a moment and replied simply, “They’re robots. That one on the left is a boy. The one on the right is a girl.” Chris was then asked if either robot had a name or if they were friends. Chris said, “No they don’t have names. The boy and girl aren’t friends, but know each other.” Chris was then asked about the lack of facial features on each robot.
“They both don’t have mouths ‘cause they don’t talk. Humans do not understand them. They can only communicate with their own kind. It’s done through thoughts. They do as their told. If someone wants the robots to do something they do it but they don’t talk.” When pressed with more questions, Chris said he had nothing more to say about the drawings.

Chris then asked if we could work on another art project. However, our time was up and I indicated as much to Chris. With a look of disappointment, Chris stated...
he would rather continue doing art than returning to the unit, and begged to lengthen
the session. I told him that we could work on another art project next week. This
idea perked Chris right up and he eagerly followed me back to his unit. As we
walked down the hall, I complimented Chris on what a fantastic job he did during
our session. Chris looked embarrassed and said, “Just don’t let anyone know, ok? I
don’t want that sort of thing getting out.” I laughed and agreed. Chris then said,
“Well, you can tell the adults, just not the kids, ok?” I again agreed and said only the
adults would be told.

One of the most striking aspects of Chris’ drawings was the small size of his
subjects (approx 4” each). By juxtaposing tiny figures against vast expanses of open
space, Chris appears to reveal a sense of powerlessness and vulnerability.
Interestingly, he further accentuated his feeling of powerlessness by drawing no
hands on either figure – hands and arms being signifiers of action, contact and
manipulation (Hammer 108). Although the female robot lacked hands, the arm
length suggested it was easier for her to establish contact with others. The boy and
girl robots in Chris’ drawings seemed to diminish feelings of inadequacy in a
stereotypic masculine fashion: their arms were positioned in a power stance—both
appeared ready to fight. This observation within the drawing was backed up by
Chris’ behavior at school and in his cottage. The cottage staff, his teachers, and
Chris’ therapist’s confirmed that he picked fights and got aggressive in attempts to
gain attention.
Session 2: Building with Tinfoil and Masking Tape

Like the first session, the second session got off to a rough start. Again, Chris claimed to have forgotten that we had art therapy and refused to attend the session. After a bit of cajoling by his case manager, Chris agreed to conduct the art therapy session in his bedroom. I later learned a lot of the therapists and psychiatrists, at this residential treatment center, conducted the sessions or interviews in the client’s bedrooms, with the doors closed, due to the clients’ refusal to leave the unit. During this session, I wanted to introduce Chris to a new art technique, building items out of tinfoil and tape. I hoped to achieve three goals: 1) continue to enhance our therapeutic relationship, 2) engage Chris in an art technique he would enjoy, since building with Legos was one of his favorite pastimes, 3) mastering a new art technique would hopefully build Chris’ self esteem. Initially, Chris ignored me as I demonstrated how to create sculptures and a variety of items with tinfoil and masking tape. He said nothing, continued to play with his Legos, and occasionally glanced up at me. Something I was doing must have caught Chris’ attention, for he began watching me, but his interest soon turned hostile.

“Why do you think I want to build things, damn, just because I like Legos doesn’t mean I always want to build things I mean everyone is always saying ‘Oh Chris always wants to play with his Legos ‘oh Chris why don’t you want to play with your Legos’ now you’re here trying to get me to build stuff and I don’t even know how to do it,” Chris’ words came out in a rush. Calmly, I explained that
because he liked Legos, I thought learning a different way of building things with regular household materials might be fun.

When Chris further expressed disinterest in working with the art materials, I suggested that we simply end the session and I come back next week. Chris immediately became angry, “You can’t do that! You’re not allowed to leave! You have to stay here.” I told Chris that in fact, no I didn’t have to stick around. After more protesting on Chris’ part, he finally agreed to make something with the art materials. Once Chris began working, he appeared engrossed in the art making process and showed little difficulty learning the new art technique. As he worked, Chris said very little. Upon completion of his piece, I asked Chris to describe it. “Hmm, I don’t know it’s a sword or a dagger it’s a mini sword,” he said. Again Chris’ words came out in a rush.

Figure 2: Tinfoil and Tape Sword.
Chris then asked if I could bring clay the next time we met. I teased him, “So this art therapy stuff isn’t too bad? You want to meet again, huh?” Chris replied, “This was a pretty bad session I’m sorry I bet you hate me do you hate me?” I told him I did not in fact hate him but wanted us not to struggle before each session. When I stood up to go, Chris became agitated, “Are you leaving, really you can’t leave let’s make some more stuff.” He grabbed at the art materials on his bed. I gently told Chris our time was up and I would see him next week.

There was a push/pull quality to Chris’ and my interaction. I found it interesting how upset Chris became when I chose to leave, in the middle of the session and at the end. It seemed Chris preferred to dictate the terms of his interactions with others. He wanted to tell me when I was dismissed and not the other way around. I could sense that Chris was testing me.

With regards to the art task, Chris liked the challenge of creating a piece out of tinfoil and tape, although in the future I would make the task more structured. The client would create a mask form with tinfoil and tape. Developmentally, Chris is right at the cusp of understanding abstract concepts, therefore providing him with a concrete task that he could artistically riff on perhaps would suit him better. The art piece Chris created did indeed look like a dagger, as he suggested. It was solidly made and had some heft to it. Considering that Chris used aggression as a means of connecting with others, his building a weapon out of the art materials was not surprising.
Session 3: Processing with Colored Clay

Because Chris had an interest in constructing structures with Legos and in a previous session asked for Legos. Furthermore, he appeared to enjoy the previous activity, building with tinfoil and tape, so I chose to use colored plasticine clay during this session. I had several goals in mind: a) introduce Chris to an artistic medium that he would find engaging, b) introduce Chris to a variety of clay building techniques in order to instill a sense of mastery, c) use Chris’ clay creations to identify and process his emotions. When I entered the cottage to pick Chris up for therapy, the entire unit was in chaos. A female client was lying on the floor unconscious and a staff member was attempting to revive her. The other clients on the unit hovered nearby with looks of shock on their faces. Still more staff were loudly ordering all of the clients to go to their rooms. I quickly walked to Chris’ room and he eagerly followed me out of the unit. This time around, I chose to take Chris over to the group therapy building and get him as far away as possible from all the chaos going on in his unit. The entire walk over, Chris chatted non-stop about what had just happened in his unit. He seemed very anxious regarding all the fighting that was taking place between the various clients in his unit.

Chris was animated as he spoke about the incident on his unit and I could tell the whole situation had shaken him up. After demonstrating several basic clay building techniques for Chris, all of which he easily copied, I asked him to use the clay to “show how he felt on the unit this afternoon.” Chris went right to work, using the colored clay to create a number of small yellow blob-like creatures. Using
the red clay, Chris created a much bigger blob like creature. He then asked for paper and colored pencils. Quickly, Chris sketched out what looked like several doors and a large eyeball (Figure 3). He was then asked to describe what his artwork. Quickly, Chris set up a mini tableau of his clay creatures, and used the sketch as a backdrop. I began clearing away a coil pot and some other clay scraps that Chris had created during the demonstration portion of our session, but Chris asked to use the coil pot in his scene.

![Figure 3: Chaos.](image)

Chris then explained that the sketch represented the main living area of his unit, and the eyeball in the sketch represented the staff. The yellow clay blobs represented Chris and his friends on the unit and the large red clay blob represented, Marissa (a
pseudonym) on the unit. Chris then demonstrated how red clay blob would attack each yellow person and put him or her “into the pot” (a.k.a. the coil pot).

![Figure 4: Clay People in the Pot.](image)

Chris then squished all the yellow people into a gigantic person and put Marissa “into the pot”. He went on to explain that Marissa was physically aggressive towards him and all the other clients on his unit. Today, several clients, sick of Marissa’s antics, had banded together and beat her up. I asked Chris to assign a title to his art piece. After some thought, he called the clay tableau “Chaos”.

At that point, Chris refused to say any more about his art piece or the difficulties in his cottage. The session ended, we quickly cleaned up the clay, and returned to his cottage. Chris’ affect before, during, and after creating “Chaos” was markedly different. He started off the session very talkative and anxious. During the art making process, Chris’ speech slowed to a normal pace and his movements became very deliberate. After the art making process was over, he was quiet and appeared lost in thought. It was as though re-enacting the drama from his unit via the clay was cathartic for Chris. It seemed empowering for Chris to direct the sequence of events, who did what, and how the drama ended. Through Chris’ eyes, the unit staff took a passive role in the drama and seemingly did nothing to protect the clients from Marissa. The clients had to band together to defend themselves. Finally, from a developmental point of view, I marveled at Chris’ ability to use the clay in an abstract way. The clay figures, both the clients and Marissa, were not concrete bodies with limbs, heads, and torsos.
Session 4: Mini Art History Lesson & Bibliotherapy

Chris’ interest in building items from clay and Legos further inspired me to introduce him to the works of artist/inventor Leonardo DaVinci. The goal for this session was to build on his strengths, namely 3-D construction, in order to continue Chris’ engagement in the therapeutic process and to reiterate a sense of mastery within him. Furthermore, I wanted to engage Chris in a dialogue about how he could share his strengths with others. In order to do this, Chris and I read a passage from the novel, *Eragon*. In previous sessions, when I gave Chris positive encouragement around his artwork, he was quick to dismiss my comments. “Miss Andrea, you have to say that positive stuff. But I’m not an artist, like you say. Building stuff out of Legos isn’t artistic”, would be Chris’ constant refrain. I would then remind him that some of the world’s most well known artists were not only painters but built things as well.

Because Chris had been well behaved during our previous sessions and enjoyed leaving the cottages for therapy, I conducted this session in the group therapy room off the unit in the group therapy building. During this session, I brought in several books on DaVinci and his work. Chris pounced on the books immediately and asked an unending stream of questions about the late artist’s work. Chris was particularly impressed with DaVinci’s inventions, specifically his helicopter/flying machine. I directed the conversation toward gifts and talents. Chris reluctantly admitted that not all his friends had the same ability to draw like him. He then became agitated and said, “But it’s not fair. Why can’t they be gifted?”
Why should only I, out of all my friends be an artist?” This was the perfect segue for the next half of our session together: learning how to share one’s strengths with others.

Chris and I read a passage from the book *Eragon*. The passage described how the hero, Eragon, found a dragon egg, knew it was special, but didn’t know what to do with it. Chris and I discussed what he would do in a similar situation.

“Chris, if you discovered that you possessed an innate strength, like Eragon’s hunting ability, what would you do with it? Share it? Keep it to yourself or something else?” Without hesitation, Chris said, “I would share it with others if I have a gift like that what’s the point of keeping it to myself?” We discussed Chris’ own gifts and how he would share them. Chris admitted to being talented at art, basketball, and playing video games. Chris said he could use art skills to build things for other people like cars and inventions. Chris then abruptly changed the topic and started asking me about religious beliefs.

“Do you believe in God, Miss Andrea,” Chris asked.

“Yep, how about you,” I replied.

“I just don’t want to go to hell. I think I am going to hell…” Chris said sadly. These comments led us into a conversation about Chris’ disruptive behavior at his cottage. Chris expressed his concerns about getting into restraints and being in trouble in school and at the cottage. As far as Chris was concerned, the staff was out to get him. We were out of time during our session, and Chris had just entered into important therapeutic territory. I desperately wanted to stay longer and process
Chris’ thought regarding his disruptive behavior. Instead I said we would table the conversation for the next time Chris and I met.

Looking back, I should have stayed a little longer and talked with Chris about his concerns. Admittedly, I’m new to conducting therapy sessions and learning the art of closure was still new to me. Getting a client like Chris to talk about anything serious was difficult, so I thought perhaps I should have jumped at the opportunity and not stuck so firmly to the schedule. I sensed, after this session, that Chris began to view me as more of an ally. Giving Chris unconditional positive regard as he explained his and other clients’ retaliation towards Marissa seemed to improve our therapeutic alliance. Looking ahead, I began to believe, Chris would be less reluctant to work with me during future sessions.

In addition, introducing other creative media, like books, seemed to grab Chris’ attention. He particularly enjoyed reading about another artist. At the end of this session, I made a note to bring in materials on other artists in the future.

Session 5: Mask Making

Chris had become so engaged in the process of building items out of clay and other art media that I wanted to continue with that momentum. I decided to have him create a mask out of tinfoil and masking tape. The directive given was “to create a mask that represents you.” My goal was again to build on Chris’ strengths to enhance a sense of mastery, engage Chris in an artistic task, and to encourage therapeutic dialogue around the concept of self. Chris was given a paper maché mask form, tinfoil, and masking tape. I quickly demonstrated how to begin and how
to possibly improvise off the mask form (e.g. create horns, a bird beak, exaggerated eyebrows).

As I predicted, Chris was eager to participate in art therapy with me when I came to collect him for our session. Tailoring art interventions to Chris’ interests seemed to hook his interest in art therapy and make him less resistant towards attending therapy. Chris started building the mask slowly, stopping every few minutes to verify with me that he was doing technique correctly. His affect was bright and conversation bubbled out of him. The pace of his speech seemed rushed. Chris’ conversation veered sharply from the past day’s events to specific staff members to his beliefs regarding hell. “I know I’m going to hell. There’s no way God will let me into heaven.” Half way through the session, Chris stopped working, smiled brightly, and said, “Miss Andrea this is so much fun! How do you always know what I like to do? I could do this stuff all the time! You always know. How do you always know?” Chris seemed genuinely surprised and pleased that I chose art activities he enjoyed.

However, the conversation took a darker turn. Chris took a strip of tinfoil and began playfully using it like a whip. I asked, “Whatcha doing?” Matter of factly, Chris replied, “My aunt and uncle use to take us out back and whip us when we were bad.” Chris’ mood appeared to darken but I probed deeper, “Do you mean they beat you and your siblings?” Chris nodded yes. He set the mask down and stared off into space.
A minute later, Chris handed me the mask and asked if I could help start the horns on his mask. Chris explained it was a devil mask. I began diligently creating tinfoil horns. Briefly, I looked up and caught Chris spreading his legs and adjusting himself—hand over his sweat pants. At first, I dismissed it as a “boy thing”. However, Chris readjusted himself several more times until he appeared fully aroused under his sweatpants. Chris then dragged his chair next to mine and spread his legs wider, as though to show off his erection to me. Unnerved, I quickly stood up and began to clean up the art supplies. I babbled something about ending the session and painting the mask next session. I was unsure of what exactly to say. Chris smiled even brighter, grabbed his jacket and followed me out of the room. As we walked to his cottage, Chris made no effort to conceal his erection. However,
right before I unlocked the cottage door Chris asked me to stop. He nonchalantly tied the jacket around his waist in an effort to conceal the erection and strolled into his cottage.

At the end of this session, I sent off an email to Chris’ therapist and his psychiatrist, asking them what I should do. I also asked the head of the group therapy department if Chris had displayed this type of inappropriate sexualized behavior during group therapy. Several days later, Chris acted out in a sexually inappropriate manner during one of his group therapy sessions. Both displays prompted Chris’ therapist to address his behavior during a therapy session the following week. In the future, I would have been more direct and immediately addressed Chris’ behavior. I could only theorize that when Chris had previously felt comfortable around a female they may have inappropriately touched him. Chris commented how happy he was around me and how I always knew what he liked to do. Given Chris’ family history of abuse his sexualized response to me, in retrospect was not surprising. However, being a new therapist, I found it shocking. I recognize that as a young female therapist it is quite likely that a teenage male client may misread my friendly tone as flirtation. In the future, when working with teenage boys, I will be a bit more formal in how I interact with them. I do not want to unknowingly provoke an already sexualized client into acting out. Furthermore, I would have verbally explored Chris’ revelations regarding his physical abuse in more depth. I admit that I was uncomfortable with hearing Chris, who normally never talked about his abuse history, discuss his past. It was a great moment
between Chris and I. Chris was opening up; from what Bruce Moon refers to as the resistance phase into the imagining phase (1998); yet I missed the opportunity explore his revelation. How I handled this session is one of my biggest regrets in all my time together with Chris.

The first five sessions with Chris were not easy. Chris moved from early resistance to a hypersexual display rather quickly. In future sessions, I hoped that Chris and I would find a solid median with regards to our relationship as client and therapist. I also wanted to continue building on his strengths, teach him to use art making as a tool for stress reduction and for emotional expression.
Chapter VI

Middle Sessions

Session 6: Drawing Emotions

One of Chris’ agency related treatment goals was “to increase his ability to identify, express, and regulate feelings appropriately.” Having worked with Chris for several sessions, I learned that his emotional vocabulary was limited. If pushed to identify how he was feeling, Chris would only articulate one of three emotions: angry, sad, happy. Therefore in this session, I set a goal to use art to enable Chris to expand his feelings vocabulary and thus his emotional awareness.

Coming into this session, I was quite anxious, because of Chris behavior in the previous session. I sought the advice from both Chris’ therapist and my site supervisor, and both recommended that I take some time during this session to speak with Chris about the incident. My site supervisor also suggested that I conduct the discussion before we enter the therapy room. This made sense because in my mind, the therapy room is no place for reprimands. Chris’ therapist also explained that his sexualized behavior was indicative of an impending manic phase.

When I came to pick Chris up from his cottage, he was all energy and motion. After Chris’ inappropriate behavior during the last session, I chose to conduct the session in the locked unit’s treatment room, where our first several sessions took place. I wanted staff to be nearby in case Chris got out of hand again. I told Chris that I wanted to speak with him before we entered the therapy room. Chris stopped and looked confused. Nervously, I dove into the conversation, “So
last week, Chris, you displayed some behaviors that were completely inappropriate. Do you remember?” Chris responded. His words came out in a rush, “Is this what my therapist, Mr. Bob, talked to me about this week? He said that I had done some things during the session I swear I didn’t do it. I don’t even remember what I did. I mean what did I do? Tell me?” What was I to say, “Please don’t masturbate and show off your erection to me during our art therapy sessions?” Instead, I sighed, “Chris, Mr. Bob was correct. You did engage in the behavior he discussed. It was inappropriate and I expect you to never do it again. Do you understand?” Chris briefly looked irritated, but his face quickly switched to a look of confusion. “Really I don’t know what I did,” Chris said his voice pitching to a whine. I decided not to argue the point, “Chris, this is the one and only time we will discuss this. Again, you behaved inappropriately and I expect you to never do it again.” With that, I turned, unlocked the therapy room door, and held it open to Chris.

I quickly got to work setting out the art materials: a sheet of large white paper, and erasable colored pencils. The white paper was folded so that it was creased into six different sections. Chris was then asked to write down a different feeling word in each of the six sections of the paper. Once he completed that, Chris would then choose a colored pencil(s) that he felt corresponded with each feeling word. Chris was asked to fill in each section of the paper with a corresponding color pencil drawing. The drawing could be anything Chris wanted it to be: a slash of color, a picture, or a series of abstract shapes and doodles. Although Chris seemed to understand my instructions, he wanted no part of the art intervention. Instead, he
began jumping around the therapy room and flinging the colored pencils at the ceiling. I attempted to re-direct Chris multiple times, however, he ignored me. Finally, annoyed, I began to gather up the art materials and place them in bag. Chris stopped and stared. In a firm voice I said, “I take it from your behavior that you’re not interested in doing art today. We’ll end for today and start up next week, when you’re in better space.” Chris’ affect changed instantly. The smile that had seconds earlier played across his lips changed to a frown. “Damn, Miss Andrea. I was just playing around. You don’t f__king have to do that—end the session. I was just joking, damn,” Chris pouted. Ending the session was my trump card, and I knew it. I smiled, “Ok, are you going to pull it together and get down to work? Are we going to do some art or what?” Chris considered me for a minute, taking in the tote bag on my shoulder and the foot halfway out the door. He sighed, “Ok. I’ll pull it together. Let’s go and do some art. Let’s go!” Chris walked over to the table and sat down—for the first time all session. I set down my bag, set out the art supplies, and sat down next to Chris. I repeated the art intervention instructions to Chris. He looked momentarily perplexed and then stated simply, “I can’t do that. I’m feeling so many things right now all at once.” Chris gathered up a fist-full of colored pencils, leaned over the paper, and began to work.
All the energy Chris had used to jump around the room now seemed to be channeled into his art. Chris pushed the drawing toward me and said, “There, that’s how I’m feeling.” The resulting drawing appeared to be a tornado funnel of colored lines.

When pressed to describe the drawing, Chris just shrugged and said, “Each colored line represents a different emotion.” No amount of prodding on my part prompted Chris to say anymore about the art piece. He began fiddling with his jacket sleeves and the laces on his tennis shoes. I took this as our cue to end the session. Quietly, I gathered the art supplies, Chris’ drawing, and my things. Still sitting in his chair, Chris said softly, “That was a pretty bad session, huh?” “Nah,
not really, buddy. You struggled a bit at the beginning; but pulled it together. And
you made some art,” I replied, “Not a bad session—not the best—but not bad.”

“You hate me don’t you,” Chris said a little more loudly. I looked at Chris and
replied, “You know what, I like you. Very much. You make me laugh all the time.
I didn’t like the way you acted today. But I still like you—that hasn’t changed at
all.” Chris got very quiet and began fiddling with a few remaining colored pencils.
He refused to meet my gaze. “Chris, sometimes, my friends do or say things I don’t
agree with or don’t like. However, that doesn’t stop me from being friends with
them,” I said simply. “Has that ever happened to you?” Still looking away from me,
Chris shook his head “No.” I began again, “The same idea hold true for us. Just
because I didn’t like your behavior today doesn’t stop me from liking you. Do you
understan…” Chris looked sharply at me his eyes flashed, “Damn, Miss Andrea, I
get it ok? I get it.” At that point, we both gathered our things and agreed to meet the
following week.

My impressions of this session were mixed. On the one hand, I wished to
have been more straightforward in discussing Chris’ inappropriate behavior (e.g. his
self stimulation). It was nerve-wracking enough for a new therapist like myself to
have that sort of a conversation with my client. However, I grew even more anxious
when Chris denied the behaviors even happened. Also, Chris’ hyper behavior during
the session, his jumping around the room, the flinging of art supplies also unnerved
me. Regardless of what redirections I gave, Chris refused to listen to me. His
actions made me feel so helpless. I remembered from a previous session that the
threat of ending the session was the only prompt that caused Chris to stop misbehaving. Initially, it seemed as though Chris could not control his acting out behaviors during this session. Even Chris’ case manager and cottage staff claimed that Chris had difficulty controlling his acting out behaviors. However, Chris’ ability to immediately stop when I threatened to leave made me believe he had more control than he let on or than I initially believed.

There were several things that went well during the session. Chris was unable to complete the art intervention, as I had planned. However, his execution of the art task revealed a great deal about Chris’ emotional state. The art piece was a chaotic swirl of multiple colored lines with each color representing a different emotion. This art piece put into context Chris’ hyper behavior. Looking at the art piece later, I thought, “No wonder the poor kid was so wound up. Look at all the different conflicting emotions going on inside him.” The other moment during this session that stood out was at the end, as Chris and I discussed his acting out behaviors. I gained a better understanding of Chris’ view of the world. In spite of his ability to create abstract art, Chris viewed relationships with others in a very concrete manner. According to Chris, if a person was mean towards you or did something you disliked, you should dislike them. Through role modeling, I attempted to show Chris that his negative behavior did not prevent me from liking him.
Session 7: Painting the Mask

Over the next several weeks, Chris and I found it difficult to coordinate our schedules to meet for art therapy. I had received more job responsibilities at the residential treatment center where this research took place and it prevented me from meeting with Chris for two weeks in a row. Each week, Chris would ask if we were going to meet. Each of those weeks, I had to tell him “no”. Finally my workload lightened up and I was able to begin having art therapy sessions again with him. However, when I attempted to schedule sessions again with Chris, he’d initially agree to the session, but then refuse therapy at the appointed time. No amount of prompting or negotiating would change his mind. Perhaps Chris was seeking retribution for the two weeks I was unable to conduct sessions. Whatever the case, approximately a month had elapsed between sessions. From what his treatment team (i.e. his therapist, psychiatrist, case manager, group therapists) observed, Chris was no longer in a manic phase. The hypersexualized behaviors, the hyper behavior, and the pressured speech were no longer observable in Chris.

Up until this point, I had been wary of allowing Chris to paint the mask he had made several sessions prior. Chris, however, had been lobbying for a while to paint the mask. Now that his manic phase had passed, I felt more comfortable allowing Chris around messy materials like paint. Nonetheless, I armed myself with trash bag drop cloths for the table and floor of the group room. Chris and I both sported paint smocks crafted from trash bags. I wanted to be prepared to unleash Chris in the same room as acrylic paints. I had three goals in mind with regards to
the mask painting. First of all, I wanted to increase Chris’ ability to self-regulate, and
using paint definitely served as a lesson in that. If I could prevent Chris from
covering the therapy room, himself, and me in paint, I would feel successful.
Secondly, painting his mask was a means of expressing his emotions. Finally, Chris
would, hopefully, find painting a mask to be a relaxing activity.
In spite of all my trash bag drop cloth preparations, Chris did not get a single drop of
paint on the drop cloths, the smock, me, or anywhere else in the therapy room. With
the skill of a Persian miniaturist, Chris gently dabbed paint onto his mask. The entire
time, his affect was relaxed and calm. When I remarked on his calm (almost Zen-
like) demeanor, Chris simply smile and said, “I find painting like this to be very
relaxing. Somehow focusing on painting just calms me.” I was prepared for the
opposite reaction.

Figure 8: Painted Mask.
Chris was uncharacteristically quiet throughout the entire session. I commented that painting could be a possible coping skill for him. “Chris, now that we both know that relaxes you. Maybe you could use it as a coping mechanism in the cottage. Perhaps you could get some paint by numbers kits to work on in your free time.” Chris nodded as he considered my suggestion, “Maybe that’d work.” Once Chris had completed painting the mask, I asked about his selection of colors. However, Chris just shrugged and said nothing. I had never seen him look so calm. Quietly, we cleaned up the room and walked back to Chris’ cottage.

I was surprised by Chris’ affect during our session together. Here I expected chaos, and Chris presented me with just the opposite. What was it about painting a mask that relaxed Chris so much? Perhaps he was in a depressed or mixed state. Chris’ treatment team, despite my inquiries, was unable to deduce why he was able to manage so well with painting the mask.

Session 8: Nature Walk

As I have mentioned, I worked at the residential treatment facility where this case study took place. Several hours before our session was to begin, I observed Chris on the phone with his case worker. It appeared to be a difficult phone call based on Chris’ reactions to what the caseworker said to him. He yelled and swore at the case worker, telling her, “You aren’t doing your f_cking job! If you found me a f_cking foster home, you wouldn’t have to worry about my behavior. I wouldn’t act up in a home. I act up at the cottage ‘cause I’m f_cking frustrated, damn!” For the next several hours, Chris acted out on the cottage—being aggressive towards
staff, shadow boxing with other clients, and jumping on the cottage’s furniture. I realized Chris was too escalated to engage in an art task, but was told by one of Chris’ group therapists that nature walks soothed him. I initially had another activity planned for this day’s session, but recognized that it would surely flop with Chris so agitated. Therefore, I decided to forgo a formal art therapy session, and take him on a walk around the campus grounds of the treatment facility.

The goals I set for this particular session were to role model to Chris how walking can act as an outlet for stress and to verbally process Chris’ behavior in the cottage after his phone call with the case worker. When Chris was informed that our session was to take place outside, a large smile crept across his face. As soon as we got outside, Chris searched the sidewalk for a large stick. He picked up and discarded several sticks before finding one that suited. Chris swung the stick aggressively at the branches of trees and bushes. He initially appeared more interested in running after squirrels and abusing plant life than talking to me. All the while, I walked slowly behind Chris letting him get out his nervous energy. Intuitively, I knew that once Chris had gotten out his pent up energy, he would want to talk with me. I trusted in our relationship enough to believe that Chris would be willing to talk about the week without using the art as a springboard. After fifteen minutes of us walking together in silence, I decided to broach the subject of his behavior in the cottage that afternoon and the phone call, “Chris, what was going on this afternoon with phone call with your case worker?” Chris stopped poking the ground with his stick and said, “She makes me so mad. My caseworker claims that
she is looking for a family for me, but she’s not doing a f*cking thing. She says that once my behavior in the cottage improves then I can go into a home. But I told her that I would be fine in a home. The only reason I act out is that I can’t stand being locked up in the cottage. It isn’t right. Kids shouldn’t be locked up.” I thought for a minute and replied, “So is that why you like pulling the fire alarm? To unlock the doors and get out?” Chris nodded. I then said, “But when you do pull the fire alarms, you never leave. So what’s the point? I’ve never seen you actually leave the cottages and go AWOL. Is it that you like knowing the option is there?” Chris replied, “Yea I guess. I don’t know. I just am a lot calmer out here,” and gestured to the trees around us. Chris then pulled me to another part of campus to show me a large pus-colored mushroom clinging to the side of tree. It was repulsive and told Chris as much. He laughed, ran up to it, and poked at it with his stick. “What is it,” I asked Chris, “about boys and gross things?” Chris shrugged and continued to poke the mushroom. Over the coming weeks, Chris would discuss the mushroom with me, as if it was a mutual friend. A conversation might go, “Hey, Miss Andrea, I saw the mushroom and it’s gotten bigger” or “Hey, the mushroom must have died. It’s no longer on the tree, but on the ground.” The mushroom would later work its way into Chris’ art as well.

After viewing the mushroom, Chris and I made our long trek back to his cottage. Chris’ affect was noticeably calmer than when we started out the session and his stick dangled limply at his side. “Chris, I’ve noticed that walking outside like this calms you down. Just like painting calms you down,” I said thoughtfully.
Chris agreed, “Maybe when I get upset, someone could take me outside.” We stopped and sat down on a picnic table outside Chris’ cottage. It was time to wrap up our session. “So Chris, what you’re telling me is that being cooped up in the cottage gets frustrating. Is it all the time or just when people in the cottage get loud,” I asked. Chris smiled, “When the cottage gets loud. It was loud this morning. Then I had that phone call with my case manager…” “Then you go off. Maybe staff should be made aware of this and we can work walks into your treatment plan. For instance, as other people in the cottage get loud, someone should take you off unit,” I replied. Chris shook his head in amazement, “Miss Andrea, how is it that you understand me so well. You and Miss Julie, and Miss Kathleen all understand me. You are all my best friends. Nobody else on staff understands me. They just put me in restraints or yell at me. ‘Chris stop that. Chris don’t do that. Chris stay in your room.’ Damn, those staff don’t get it.”

I smile and scrambled for what to say. Chris did not readily admit to being friends with others. Not only did Chris consider me a friend, I was one of his best friends. This was no small admission. Although his statement flattered me, I wanted to remind Chris that I was still just his art therapist, “Chris, I’m honored that you consider me to be one of your best friends. However, I’m not a friend but your therapist. You realize that?” “Damn, Miss Andrea, don’t say that! You are my best friend. You Miss Julie, and Miss Kat are all my best friends. They all say the same thing too—no Chris we’re you’re therapists or your staff,” Chris said angrily his mouth twisting into a frown. I decided to change the direction of the conversation
back to the soothing properties of walks. “Chris, getting back to the whole business of walks. What if I tell your case manager and cottage staff that when the cottage gets too loud or you get escalated—if there is staff available—to take you outside or at least out of the cottage,” I said. Chris nodded and said, “That sounds good. I could do that.” I thought for another moment and said, “Now Chris, if there is not enough cottage staff to take you outside when things get loud, what else can you do? Let’s think of some ideas.” Chris thought for a moment and then replied, “Go to my room, listen to my cd player, play the cottage Game Boy.” I smiled, “Those are all great ideas! It seems to me that this has been a fairly productive session. What do you think?” “Yea, it’s helped. I just wish there were always enough staff to take me on walks when I need it,” Chris sighed. At that point, we both hopped off the table, Chris dropped his stick, and we went back into his cottage.

My instincts about taking Chris on a nature walk, in place of doing art, were correct. Running around outside seemed to act as a pressure valve for Chris. All the pent up frustration from being cooped up on unit and talking to his case manager was gradually released as Chris moved around. After speaking with Chris regarding his feelings about living in a locked cottage, I could understand why he later became so aggressive after the phone call with his case manager. It was as though Chris was in a Catch-22 situation. Being in the cottage over stimulated him, thus prompting him to act out. The case manager told Chris that she could not place him in a home until he stopped acting out. However, the only way, in Chris’ mind, for that to happen was for him to move to a foster home. I suggested to Chris that he develop coping
skills of his own, which he did. During this session, Chris and I spoke more to each other than ever before. I was again impressed by Chris’ insight into his own mental process. Realistically, I believed it might take Chris some time to start relying on his coping skills when things got out of hand in his cottage. Chris admitted to never having used coping skills before when the cottage overwhelmed him. Only time would tell.

Session 9: Build Your Ideal Treatment Center/Chris Gets Sick

During a meeting the following week, I shared with Chris’ treatment team what he had shared with me during our walk. This led to a team discussion about finding Chris a foster home. All the team members agreed that this treatment facility might not be a good fit for Chris. The team members then spent time discussing how best to accommodate Chris until a foster family was found. The treatment team’s discussion sparked an intervention idea in my head. I decided to have Chris “Build His Ideal Residential Treatment Facility.”

When we met for this session, Chris appeared lethargic and tired. Because of his low energy, I chose to have the session in the therapy room within the locked unit down the hall from Chris’ cottage. Chris complained of a headache and chills as we entered the therapy room. I set out popsicle sticks, tape, and glue in front of Chris and gave him the directive to “build his ideal treatment facility.” But Chris just laid his head on the table and closed his eyes. His reaction worried me. Chris admitted to talking with staff that morning about not feeling well, but said, “they didn’t take me seriously.” I asked Chris if he wanted to go back to his room and lie down.
Chris said, “no” and began half heartedly to pull popsicle sticks out of their container. He really was not acting like himself at all. Chris was not talking, his eyes appeared glassy, and his movements were slow. I made an executive decision right then and there. “Chris, stop what you’re doing right now. We’re going to see the nurse,” I commanded. Chris just shook his head no and continued pushing popsicle sticks around the table. “I mean it Chris! I’m not playing with you. You are too sick to be doing this right now. First the nurse and then to bed. You’re wearing a jacket and still shivering. It’s comfy in here. I bet you have a fever. I’m taking you seriously, so let’s go—now,” I ordered and pulled Chris to his feet.

By this point, Chris needed assistance walking down the hall. “My belly hurts,” he moaned. “We’re almost at the nurse’s station, hold on,” I said in my most efficient tone. The nurse’s station was down the hall from the therapy room. When I found one of the nurses on duty, I began to fill her in about Chris’ condition. She briskly cut me off, “No, I am not dealing with you right now Chris. I have too many other things to do at the moment.” Chris began to grumble under his breath about the nurse. With a hand on Chris’ shoulder, I looked the nurse square in the eye and said, “Look, Nurse Shanti, I realize you’re busy, however, I truly believe Chris has a fever. He also has had belly pain all day and told staff about it earlier. Please, check this poor boy out.” Nurse Shanti looked up from her paper work, a surprised expression on her face. She got to her feet and led Chris into an examination room. A few minutes later, the nurse told me what I already had intuited; Chris had a bad fever and needed to lie down. The nurse promised to check on Chris within the hour,
once he was in bed. I told Chris the art therapy session was cancelled today and we could finish the project next week. Chris expressed disappointment at not being able to work on the art task. Chris then looked up at me, his face filled with awe, “Miss Andrea, thank you so much. You saved my life!” “Chris, silly boy, you’re not dying. You’re sick, but we’re taking care of it,” I said with a laugh. “No, Miss Andrea, nobody else believed that I was sick, but you did. You were the only one. Not even the nurse believed me. She’s such a b_tch can’t believe she said that. She should be fired. Not even staff believed me, but you did. Thank you.” Even with a temperature, Chris could talk a mile a minute. The cottage staff was informed of Chris’ fever and he was hustled off to bed. I would later find out that Chris visited the emergency room later that evening, was treated for a gastrointestinal infection and released.

Looking back on the session, I was surprised that both the cottage staff and the nurse were reluctant to take Chris’ complaints of illness seriously. Working in Chris’ cottage, I saw that he was both verbally and physically abusive towards the staff and the nurses. Perhaps the staff and nurses overlooked Chris’ complaints out of frustration with his acting out behaviors. Having worked closely with Chris over the past several months, I was aware of his normal affect, when he was in a manic phase, and every mood in between. Chris, during this session, was not acting like himself, no question.

While I have no doubt that another staff member would have noticed how sick Chris was, my response to Chris seemed to deepen his trust in me. Chris rarely
asked for help from the staff. Yet when he needed the staff’s help, no one—not even the nurse took him seriously. I was his advocate that evening and our bond was strengthened as a result.

Session 10: Build Your Ideal Treatment Center Part 2

Because Chris had been unable to complete the “build your ideal treatment center” task from the prior session, I decided to attempt this intervention again. My goals for this particular session were to increase Chris’ problem solving skills, empower Chris to re-build an environment he finds oppressive, increase Chris’ sense of mastery by introducing Chris to a new art medium (popsicle sticks), and initiate a therapeutic dialogue regarding Chris’ views on living in a residential treatment facility (i.e. how can he find ways to cope in the here and now). The materials for this particular art intervention included multicolored Popsicle sticks, craft glue, colored masking tape, and colored markers.

When I picked up Chris for this session, he was no longer sick and appeared eager for the art therapy session to start. “Miss Andrea, it’s time for art therapy. Good! Let’s get out of here. What are we going to do today,” Chris asked as a big grin spread across his face. By now, Chris’ resistance towards art therapy sessions with me had fully abated. As I mentioned earlier, his recent streak of resistance may have been retribution seeking. Perhaps Chris’ resistance was connected to his abandonment issues. His biological family was not trustworthy, his foster families had given up on him, Mr. Bob, and Chris’ therapist recently retired and left him. Now, his art therapist was becoming unreliable. Perhaps Chris’ latest round of
resistance was meant to test my loyalty towards him. However, now that I was consistently showing up for art therapy again, I had apparently passed the loyalty test and Chris’ trust in me began to return.

Because it was raining outside, neither of us wanted to trek over to the group therapy building; Chris and I agreed to hold our session in the group room on the unit. I re-introduced the task to Chris again, and he immediately set to work. As with painting the mask, Chris took his time slowly constructing a building from the colored Popsicle sticks. He experimented with breaking the sticks and taping them together. Chris spent long periods of time simply peering at his structure and imagining how next to proceed. “Miss Andrea, this is really tough,” Chris sighed as he picked up two more sticks. “I’m sorry, buddy. Do you want to do something else or stick with this activity,” I replied. “Nah,” Chris said as he scrunched his brow in concentration, “let me keep working on this.” I had never before seen Chris so deep in concentration with an art task before, except for the session during which he painting the mask.

“What part of the treatment center are you working on currently,” I inquired. “My bedroom,” Chris mumbled. He appeared to still be deep in concentration. The session was nearly over when a din of boys’ voices broke our silence. I looked up and saw a group of boys from other cottages swarm into the room. Behind the boys trailed a group therapist, Aaron. The boys all greeted Chris and me with shouts and high fives. Chris instantly appeared embarrassed as one of the older boys slid next to him and inquired, “Hey, what are you guys working on here?” Feeling protective of
Chris and his art piece, I quickly pulled the Popsicle stick creation into my lap, and smiled up at the boy, “Don’t worry about it, Tyrell. Chris and I have art therapy together on Mondays; so we were finishing up our session. Not to keep you in the dark, but anything Chris and I do in therapy is confidential. You can understand that.” Tyrell, who was a long term resident at the treatment center, nodded his head in understanding. Aaron approached both Chris and me with an apologetic look on his face, “I’m sorry you guys. Normally, we’re never in here. But the rain was so awful. We really didn’t mean to interrupt. If I had known…” I cut Aaron off mid-sentence and said, “No worries, Chris and I were simply wrapping up.” Aaron looked relieved, “Good thing too, cause Chris has been added to this group. Do you want to join us Chris? I promise that’ll you’ll have so much fun!” Chris paused for a moment and looked towards me. I smiled encouragingly towards him, “Go on, buddy. Have fun! I’ll put up your art piece and we can work on it at the next session.” Chris nodded his head “yes” and moved around the group room to be closer to one of his friends. I gathered up the art supplies, carefully tucked Chris’ Popsicle stick masterpiece into my tote bag, and left the room.
I was a bit disgruntled that our session ended so abruptly. Chris and I never got a chance to discuss his art piece, why he enjoyed working on it, and in what direction his art piece was headed. Furthermore, Chris and I were never able to discuss what practical measures he could take to shape his environment and make it more enjoyable. After learning from Chris how trapped he felt in the locked cottage, I intuited that this art task would engage him. I also theorized that Chris’ love of building stuff would also make this art therapy intervention a big hit. With the exception of painting his mask, Chris was ordinarily hyper during our sessions together. Even during the nature walk, Chris was full of wild energy until nearly the end. However, this art therapy intervention pulled Chris into a state of concentration he ordinarily reserved for playing his GameBoy or building with Legos.
During these middle stage sessions, I felt a strengthening in my therapeutic relationship with Chris. As I previously mentioned, Chris’ trust in me had deepened. The solid relationship I hoped to develop with him was now a reality. Based on his verbal and nonverbal behavior, Chris seemed to view our art therapy sessions as a treat and not something he “had to do.” Interestingly, Chris, according to his treatment team, was still resistant towards group therapy, despite being placed in a large number of expressive arts therapy groups. Chris was not as resistant to individual therapy and thrived, according to his treatment team, when receiving individualized attention. As Chris mentioned during one of our therapy sessions, communal living was difficult for him.

My goals for our last set of sessions together, was to continue showing Chris how use art making as a form of stress reduction. Other goals for the final sessions included: to continue teaching Chris how art making can be an emotional outlet and to increase his self esteem through mastery of various art media.
Chapter VII

Final Sessions

Session 11: The Session That Never Was

Because Chris enjoyed building with the Popsicle sticks, I decided to continue on with the same intervention, “Build Your Ideal Treatment Center”, from last week. During this session, I wanted to make sure Chris and I were able to have a discussion regarding his views on living in a residential treatment facility, and how he could find ways to cope with this situation in the here and now.

When I attempted to retrieve Chris for our session, he appeared agitated. Chris was arguing with two of the cottage staff members and jumping on the furniture in the cottages main living area. He started cussing out the staff, other clients, and began kicking the locked door of cottage’s library. I felt uncomfortable taking Chris out of the cottage when he was so escalated. Staff confirmed that Chris should remain on the unit as well.

I turned my attention back to Chris, who was now attempting to smack one of the male staff members. “Chris, come here for a minute,” I called. Chris turned his focus away from the male staff member and trotted over to me. He began to shadow box my torso and face. “Buddy, you are too wound up to have art therapy just now. I’m not going to lie, I don’t feel all that comfortable taking you out of the unit,” I said simply. Chris’ smile instantly faded and he began to yell, “Not you too, Miss Andrea! That’s not fair. I was fine until those f_ckers started messing with me. The staff is always messing with me. I’ll be fine off unit. Damn, let’s go!” My instincts,
however, told me differently. I was not about to take Chris off unit when he was in such a state. “Chris, NO, we are not going to have art therapy. You were fine five minutes ago, but then YOU chose to start yelling at the staff. YOU decided to jump on the furniture and kick the library door. Chris, it’s no use arguing with me. You and I will have art therapy next week but not today.”

When Chris heard this, he grew more escalated. He cussed me out and flipped the cottage’s garbage can over; its smelly contents tumbled onto the floor. That was a major infraction of the rules and Chris knew it. Two of the cottage staff members grabbed Chris and escorted the boy down to his bedroom.

Looking back on the situation, I do not regret my decision to cancel the session. I knew I would be unable to manage him during our time together. It was a fairly common practice amongst all the therapists, at the treatment center, to prohibit clients from attending therapy sessions if the client was escalated.

However, there was an upside to Chris’ tantrum. Ordinarily, getting him to attend group therapy, school, or his individual talk therapy sessions was close to impossible. He did not view missing out on all those things as a consequence. Working within Chris’ cottage, I saw this firsthand. However, his reaction to attending art therapy sessions was different. By now, Chris attended art therapy willingly, cheerfully. Based on Chris’ comments regarding the art therapy interventions and his willingness to attend the sessions, he seemed to truly enjoy our time together. Chris viewed our art therapy sessions as one of the few good things in
his life. Therefore, being prohibited from attending art therapy was, in Chris’ mind, a consequence.

Session 12: Sitting Outside

During this session, Chris refused to leave the unit. He had just gotten off the phone with his caseworker. Nowadays, all the phone calls with his caseworker upset him. Chris wanted to live with a foster family more than anything, and he felt that his caseworker was dragging her feet. I overheard the tale end of the phone conversation and it had been full of recriminations, cussing, and angry shouts—all coming from Chris. When the phone call ended, I gave Chris two options: a) we have a typical art therapy session off unit or b) we sit in the outdoor courtyard adjacent to the locked unit and simply talk. I intuited that Chris was too wound up to focus on completing a therapeutic art task. All his energy had been exerted during the phone call. Chris complained of fatigue and chose to sit out in the courtyard. I mentally scrambled to rearrange my treatment goals for the session. I chose the following two session goals: Chris will use his words to appropriately express his emotions regarding waiting for a foster home; and Chris will come up with ways of appropriately communicating concerns and needs to his caseworker.

I asked the cottage staff if Chris and I could not be disturbed in the courtyard during our therapy session. The courtyard is only accessible through four locked doors. It is located between the client cottages and the client gymnasium. Two doors lead into the gym and the other doors lead into two separate cottages. The courtyard was a small space 20’ by 20’ blanketed mostly in weeds, bare patches of
earth, and some grass. The rest of the courtyard was composed of two cement slabs meant to serve as individual patios for each cottage. Two separate metal picnic tables sat on each slab.

Chris and I settled onto the table of one of the picnic tables. Without much prompting, Chris angrily began to re-hash the phone call with his case manager. According to Chris, his case manager reiterated that she could not place him in a home until he stopped acting out. However, the only way, in Chris’ mind, for that to happen was for him to move to a foster home. It was the same complaint Chris had during one of our previous sessions. It was the same old Catch-22 situation. As I listened to the boy complain, I contemplated how to respond. For all our sessions, I had never truly put pressure on Chris to own up to his disruptive behaviors in school, in his cottage, and in group therapy. Our rapport was firmly established; and I knew that our relationship could withstand the pressure of my inquiries into his negative behaviors. “So, Chris,” I began, “you claim that your behavior is within your control. Is that correct? That if you really wanted to act appropriately in school, the cottage, therapy that you would?” Chris looked down and said with exasperation, “Yes, Miss Andrea, I could. I just can’t believe my stupid…” I cut Chris off, “Hold up, buddy. I know you’re angry with your case manager, but I’m just trying to understand. If you know that good behavior is your ticket out of this joint, why not behave yourself? Why not act appropriately? What are you getting out of acting out? You know the consequences of acting out: early bedtimes and writing assignments. You hate all of those.” Chris looked up at me and said, “I don’t know.
You guys need to help me! I’m here to get help and it’s up to you guys to show me what to do. Damn…I’m stuck here to get my treatment and someone needs to help me.” I leveled my expression at Chris and decided to speak frankly, “Look Chris, I realize that you’re here in treatment and you’re looking to the staff for help. But I’m going to be honest with you Chris; you need to work hard as well. You need to attend group therapy and pay attention. Group therapy is 75 percent of your treatment. Did you realize that? Listen to your group therapists, listen to your therapist, and listen to staff. All those things, I’m sorry to say, I don’t see you doing.” Chris sighed but nodded his head in agreement.

Chris and I discussed his options regarding how to cope in the cottage and manage the mood changes brought on by his mental illness. Chris admitted to not trying to use the coping skills that we had discussed in previous sessions. I asked Chris to tell me of two coping skills that he could practice that week if life in the cottage got difficult. “I can ask to take a walk with staff or take space in my room. I could play with my toys in my room,” Chris said gravely.

I was surprised at how candidly I spoke toward Chris. Admittedly, I’m a non-confrontational person. However, I intuitively knew our therapeutic alliance could withstand whatever criticisms I threw at Chris. Although, looking back at our exchange, I did approach his negative behaviors in a gentle manner. By having Chris view his behaviors objectively, he would hopefully see the contradictory nature of his statements. On one hand, Chris claimed that controlling his negative behaviors in school, the cottage, and therapy would be his ticket out of residential
treatment. Chris denied that his behavior was out of his control. These pronouncements led to my question, then why don’t you stop acting out? At this point in the conversation, Chris changed denial tactics. This time, staff should show him how to behave and help him. He was in treatment and it was up to staff—not him to fix the bad behaviors.

Session 13: The Infected Clay Log

Shortly before this session occurred, Chris had been involved in a major fight during one of his therapy groups. In brief, Chris had witnessed two of his therapists restrain a peer during group therapy. The peer called out for Chris to help him. In turn, Chris pulled a fire extinguisher off the wall and blasted it at the therapists in the restraint. This led to further chaos within the group. Chris and his peer were later dismissed from the group and severely punished for their actions. For the rest of the week, Chris refused to attend group therapy, school, or individual therapy sessions. He kept to himself in his room and refused to discuss the fire extinguisher incident with any staff member. The following week, Chris agreed to attend art therapy. I decided to have Chris discuss and process the incident by using clay. During session 3, Chris responded well when asked to process a difficult situation using clay. My first goal for this session was to have Chris use the clay to process his behaviors and their underlying motivations during that fire extinguisher incident. The second goal was for Chris to use the clay to come up with an alternative means of handling the situation. Chris and I conducted the session in my office on unit, because my job, as assistant cottage supervisor, prevented me from leaving the cottage at the time.
When Chris arrived in the office, he appeared to be pretty upbeat. He was smiling, cheerful, and full of jokes. I laid out chunks of blue, yellow, green clay and some clay tools. Without much of a preamble, I said, “Chris, use the clay to illustrate what happened last Monday during group.” Chris needed no further explanation, and quickly picked up a lump of red clay. He began to shape and mold the clay into a large rod shape. Chris appeared deep in concentration as he worked on the clay piece. When he was done, Chris looked up and cradled the clay shape in his palms (Figure 10). “Ok, buddy,” I said smiling, “tell me about your clay piece.” Chris looked down at the clay piece, thought for a minute, and said gravely, “It’s a log.” “A what,” I said confused, “but how does this log relate to last Monday’s group?”

![Figure 10: Clay Log.](image)

Chris leveled his gaze at me and said, “Ok, you remember that tree with the fungus we saw on our walk awhile back?” I nodded. Chris continued on, “So the tree was the group. Michael and I were the fungus growing off of it. The tree couldn’t
protect itself and so the fungus grows up out of it. The fungus infects the log and ultimately hurts it.” I looked at Chris in surprise and said, “So what you’re telling me is that the group, represented by the log was undefended? Did the group feel unsafe to you that day?” Chris nodded, “If it had been run properly, all this stuff never would have happened.” I replied, “Your and Michael’s behavior were the result of a poorly run group? Was the group feeling unsafe to you?” Chris nodded and said, “Yea, we were the fungus. Like the fungus destroys a tree, we destroyed that group.” Chris began rolling the clay log between his palms making it grow long. The log took on a phallic quality and I flashed back to Chris’ masturbation during a previous session. I had also observed Chris’ hypersexualized behaviors towards the female staff on the unit. With those things in mind, I decided to end the session a bit early. I thanked Chris for his art piece and his candor. Right before I stood up to leave, Chris walked toward me and said, “Hey Miss Andrea, can I have a kiss? Please?” I said, “No” and directed Chris to the door.

Later, I spoke with one of the group therapists, Nick, who had witnessed the chaos of the fire extinguisher incident. I shared with him Chris’ thoughts and art piece from this session. Truthfully, I felt that Chris was again throwing the blame onto someone other than himself, but was amazed at the analogy he created from the clay log. Nick smiled and nodded in agreement as I spoke. “Actually, Chris was really right on the money with his observations,” Nick said softly, “The group was not being run appropriately and became out of control.” I was surprised by Nick’s answer. Looking back at the session, I still marvel at the sophisticated way Chris
took an element from his environment and used it as an analogy for a difficult experience. As with the previous session, Chris was looking at staff to offer support and protection. However, he was not getting it.

My intuition regarding Chris’ hypersexualized clay piece was correct; he was in the early stages of a manic phase. Fortunately by now, Chris’ psychiatrist had a firm handle on how to manage his mania through medication. Therefore, this manic phase was less pronounced than previous ones. Chris no longer grossly sexually inappropriate with staff and other clients. However, he did demand an excessive amount of hugs from the female staff. Chris was able to ask for the hugs appropriately, instead of simply grabbing a staff member, as he had previously done. He also knew it proper only to give side hugs to staff and did just that. He no longer improperly displayed his genitals to female staff; however, he was out of line by asking me for a kiss.

Session 14: The Gift

This session took place a few days before Chris’ 14th birthday. When Chris arrived in my office for the session, he was full of chatter about his upcoming birthday party, the presents, and the cake. As a reward for Chris’ hard work in art therapy and also as a pre-birthday treat, I granted his long-standing request to do some art on the computer. After opening up a computer drawing program, Adobe Illustrator, on my office computer, I demonstrated for Chris some of the basic tools: the pencil, the eraser, the shape tools, the paint tool, and the symbol tools. My goals for this session were: to increase Chris’ sense of mastery by introducing him to a
new art medium and have Chris create an art piece, via the computer, around the concept of gifts. The second goal was meant to tie the art task to Chris’ upcoming birthday, stimulate a therapeutic dialogue about his inner gifts and wishes for the future.

Chris began to explore the software program with some unease and was hesitant in his movements. He was unable to settle on any sort of a picture. Chris would draw a few lines onto the screen, and then erase them. Chris would test out different size brushes, various colors of paint, and an assortment of shapes. I was briefly called out of the office to answer a colleague’s question. When I stepped back into the office, Chris had created a picture and wanted to show it to me. He had created a happy birthday sign for himself (Figure 11). Chris was quick to point out that he included his name and age in the drawing by using a more abstract brush.

Figure 11: Happy Birthday Sign.
I praised Chris’ mastery of the computer art program. Then I asked Chris to draw a gift with the program. Chris used the program to create a simple line drawing of a wrapped package (Figure 12). Then Chris was asked to envision his ideal birthday gifts. Chris screwed up his brow and thought for a moment. “Besides my own GameBoy,” Chris said with a smile. I rolled my eyes at him and laughed at him. We both knew how long Chris had wanted a GameBoy, after breaking his old one. “Yes, Chris, besides a GameBoy,” I said laughing. “Well, I want to see my brother and sister, to get out of [residential treatment]…” Chris began. “My own foster family, a job as a game designer, my own home,” he continued. Now Chris was on a roll, and a huge smile spread across his face. “To be married, to have kids, to have a dog, a cat, a bird, no not a bird, and a snake,” Chris finished. I smiled at Chris and said, “Thank you so much for that answer. That was awesome. Those are some fantastic
gifts!” Chris beamed with pride at my response. “Chris, since we’re speaking about gifts, what gifts do you have that could be shared with others,” I asked. Chris thought for a moment and then said haltingly, “My drawing ability?” I nodded encouragingly. “My sense of humor, um, my creativity,” Chris continued. He looked stumped. “Anything else,” I asked. Chris looked down and then said, “My friendship? That’s it.” I smiled and said, “Those are some pretty incredible gifts to share with others, Chris.” The boy nodded his agreement. Chris then looked at the clock on the computer, “Are we done now?” Our time was up.

Chris’ reaction to exploring a new art medium surprised me. Outside of our session, Chris’ behavior was impulsive. I expected Chris to be more spontaneous when working with this new art medium. What really impressed me were Chris’ responses to my questions regarding gifts. That was the first time Chris had ever voiced his wishes for the future. Chris rarely spoke with anyone about his future plans; and I felt honored that he had shared them with me.

Session 15: Final Session

For the past several sessions, Chris had been opening up to me regarding his feelings and enjoyed using art to express himself. Therefore, his treatment team and I agreed that Chris would continue on with art therapy. However, our final session came about abruptly. Chris’ caseworker had found him a foster family. I was thrilled when I first heard the news. One of Chris’ birthday wishes had come true! Chris was thrilled with the news as well. For our final session, I decided on the following goals: Chris would use the art to express his feelings regarding leaving the
treatment center for a foster family and use the art to gain some closure regarding our art therapy sessions.

Chris asked to conduct the therapy session within my office in the cottage. He was in a good mood when the session got started. I set out a variety of art materials for Chris: various colors of clay, a tablet of drawing paper, colored pencils, a couple of #2 pencils, paint, and paint brushes. Chris was asked to select an art medium of his choice and use it to express his feelings regarding going to the new foster family. Chris picked up the yellow and green clay.

![Figure 13: Chris’ Spout.](image)

After working with it for several minutes, Chris showed me his art piece (Figure 13). “Ok, bud, tell me about it,” I asked. Chris smiled and said, “It’s a baby plant that’s just beginning to sprout.” “Can you tell me anymore about your plant,” I asked but Chris shook his head “no.” Then, riding a wave of intuition, I asked Chris to draw himself as a superhero—our very first art task together. Chris grabbed the
tablet of paper, a #2 pencil, and began to draw. Several minutes later, he presented me with a drawing of a small man wearing a cape (Figure 14). “Can you draw me a female superhero now,” I asked Chris. He shook his head “no”. “I’m done,” Chris said simply. I changed tactics. “Well, at the very least, can you tell me about the guy superhero,” I asked with a smile. Chris looked at the drawing thoughtfully and then spoke, “Well, he can fly. See his cape. And he’s got lots of gifts. But he doesn’t want to brag about them. So he’s going to use them to help others. That’s it.” I looked at the drawing a little more closely. “That’s a great drawing, buddy,” I said. Chris nodded in agreement. “This is our last session together.

![Figure 14: Chris’ Second Super Hero.](image)

This time tomorrow, you’ll be on your way to the foster family. How are you feeling,” I asked. “I can’t wait. I wish I could leave tonight. Don’t get me wrong, I’ll miss some of the staff, but I want to go. But I’m nervous. I don’t know if I’ll like it there. I don’t like my foster mom very much,” Chris said with a sigh. For the
past week and a half, Chris had been having trial visits with the new foster family.

“Why not? What’s up with the mom,” I asked. “She’s always telling us what to do. There are all these rules. I have to ask to do anything and I have to share a bedroom,” Chris moaned. I nodded sympathetically. “Bud, it sounds like it’ll take some time to adjust. Luckily, you’ll be attending group and individual therapy at a place nearby. Therefore, if you run into problems, you can use those therapists to help you out,” I replied. In addition to living with a new foster family, Chris would be attending a partial hospitalization group therapy program after school. Chris nodded in agreement and handed the two art pieces off to me. “Don’t you want these art pieces,” I asked him. “Nope. They’re for you to remember me by,” Chris replied. We spent the last few minutes of the session laughing and reminiscing about the various art pieces Chris had created. “I hope I can still do art therapy at my new place,” Chris said as he left my office. “I hope so too, buddy,” I replied, “I hope so too!”

During our last session together, Chris caught me off guard with both his art pieces, unbeknownst to him. Chris’ baby plant really seemed to illustrate a new beginning. It was not a tiny sprout, but a big solid looking stalk. Although Chris chose not to speak about the plant, perhaps it was his way of looking ahead to new experiences. Chris’ superhero drawing also surprised me. His comments about gifts and sharing gifts impressed me. Perhaps the previous birthday themed session was in Chris’ head still. It must have made some impression, because he included it in this drawing.
After this final session, I reflected back on how far Chris had come regarding his willingness to engage in art therapy sessions with me. I felt that through maintaining consistent and firm boundaries, I was able to create a therapeutic holding space where Chris could safely share his feelings and thoughts.
Chapter VIII

Conclusions and Recommendations

After reviewing the information gathered from the sessions with Chris, there were a number of conclusions I was able to draw. After interviewing Chris’ case manager, the staff in his cottage, his ph therapists and through my own observations, I learned he was a reluctant participant in both group and individual therapy. Oftentimes, Chris would consistently leave group or talk therapy early or refuse to attend these sessions altogether. However, Chris’ response to art therapy was different. A review of all our sessions together indicated that he consistently attended and remained in the art therapy sessions the entire time. He later explained that art therapy “was fun” and specifically cited “doing art” as the sessions’ drawing card. Chris specifically responded well to art interventions that were tailored to meet his interests. In his free time, Chris enjoyed building things out of Legos. Therefore, art therapy interventions that incorporated sculpture were well received.

My work with Chris also provided a number of good lessons, for me as a therapist, specifically with regards to working with adolescent clients. Namely, therapists working with population should be aware of how they may be perceived, particularly by a client of the opposite sex.

Art therapy interventions seemed to act as a bridge between Chris and myself. As seen in sessions 1 and 2, Chris was initially reluctant to attend art therapy sessions. Once Chris was asked to engage in the art task, he would participate. Furthermore, he was reluctant to leave art therapy sessions when our
time was up. Chris would ask to do another art intervention. Chris’ art pieces from
sessions 1, 3, 5, and 6 offered insight into his emotions despite his inability to do so
with words. The superhero art pieces in session 1 revealed a great deal regarding
Chris’ self-concept. Specifically, his stiff robots appeared ungrounded and
powerless. Chris’ later explanation of their limited communication abilities appeared
to mirror his own communication limitations. His case manager later confirmed that
communication was an area of growth for Chris. The clay pieces Chris created
during session 3 again touched on the theme of powerlessness. Chris had the large
clay “Marissa” attack all the tiny clay people. He then had the little clay people gang
up on “Marissa” and retaliate.

During session 5, the devil mask Chris created evoked memories of the
physical abuse he endured growing up. Chris had previously never discussed the
abuse with me; and shared only the factual information relating to his abuse (i.e.
who, what, where). However, Chris explained that a devil mask was a natural choice
for him, since he was a bad person. When asked to clarify what about him was bad,
Chris was unable to say. It’s not uncommon for abuse victims to view themselves as
bad people, who deserved the abuse they received. The art seemed to reflect a
dimension of Chris’ self-concept, even if he could not articulate his emotions
regarding the abuse. Session 6 was also a strong example of Chris’ inability to
verbally articulate emotions, but he demonstrated a capacity to use the art to
illustrate what he was feeling.
Tailoring the art therapy interventions to match Chris’ interests seemed to enhance his engagement in the tasks. During session 1, I sought to uncover Chris’ hobbies and interests. Chris spent a great deal of time during session 1, discussing his Lego creations and a Lego video game he enjoyed playing with friends. Therefore, I purposely chose art media and interventions that allowed Chris to construct things. Because the theme of powerlessness reappeared within several of Chris’ art pieces (e.g. sessions 1 and 3), I purposely chose art therapy interventions that allowed Chris to re-shape his reality. During his initial assessment, Chris seemed so powerless by his life in residential treatment, reshaping his world would hopefully empower him. During session 5, Chris was instructed to create a mask that represented how he saw himself.

Furthermore, allowing Chris to work with sculptural media seemed to increase his self-esteem. Chris already a natural affinity for building things (e.g. Legos) therefore developing that strength would serve to increase his self-esteem. In later sessions (9 and 10), Chris was asked to build his ideal treatment center out of Popsicle sticks. As we worked together, Chris and I discovered he had a special affinity for working with clay. It was an art medium Chris appeared to enjoy. Oftentimes, Chris would enter the therapy room in a hyper state, and would be quite literally jumping on the furniture. Hand Chris a wad of clay, however, and all his energy would be focused into making an art piece. It was also the art medium Chris felt most comfortable using, and he would routinely start off a session by asking if clay would be used. Although I asked Chris several times why he found clay so
enjoyable, I never received a definitive answer. Chris would only say that he found it easy to build with clay and that it was fun.

Also, while the art interventions did engage Chris and kept him returning to therapy, the strong therapeutic relationship we established also played a large role in his engagement. Our bond grew over our time together, and we seemed to develop an easy rapport with one another, despite Chris’ unwanted romantic advances during a couple of our sessions. I learned that how I presented myself greatly impacted Chris’ response to the art therapy interventions. Chris responded well to my enthusiasm towards the tasks and our time together—regardless of his behavior. He could be breaking oil pastels, jumping around the room, making silly jokes; and I would not appear irritated. Inside, I might be rolling my eyes or frustrated. Chris later remarked on my demeanor, “Miss Andrea, you’re always in a good mood. Why is that? No matter what’s going on, you’re happy. Always happy.” From working in Chris’ cottage, I had seen often seen other staff yell at or scold him. He received enough negative attention in school, in the cottage, and in group therapy. I decided to employ the humanist concept of unconditional positive regard. If I needed to redirect Chris, I always remained calm and kept my voice pleasant. Chris seemed to respond well to this approach in our therapy sessions, and rarely would I need to redirect him more than once. I also credit our strong bond to my willingness to remain flexible and use Chris’ input to shape our sessions. During some sessions (8 and 12) he wanted to walk outside, and other sessions (13 and 15) Chris wanted to
use clay. Because so much of Chris’ life was controlled, I felt it important to allow him some control over how our time was structured.

I also found that our sessions together did fall within Bruce Moon’s phases of adolescent art therapy (1998). Sessions 1 and 2 were indicative of the resistance phase. In both sessions, Chris’ behavior indicated that art therapy and the art therapist were foes to be fought. During sessions 3, Chris transitioned into the imagining phase; he indicated his need for support and stability through the creation of his clay tableau (Moon, 1998). This need for stability, containment and support appeared again during session 4, as seen by Chris’ revelation regarding his past abuse and his sexual advances towards me. It later reemerged again during session 13 when Chris created the infected clay log. Using the creation of the clay log as a jumping off point, Chris and I discussed his need for structure and containment during therapy groups. Chris did not enter Moon’s third phase, the immersion phase, until nearly the end of our time together. Chris, try as I might, had a great deal of difficulty taking ownership for his present emotional and behavioral difficulties. It was not until the very last session, when Chris created the second super hero, that I saw him create a more positive representation of himself. During 4 and 6, when he created the devil mask, Chris kept identifying himself with something bad and rotten. Again, during session 13, Chris identified himself with a fungus that infects living healthy things. However, in the last session, Chris created a grounded superhero, which “has gifts to share with others”. He also created a clay sprout, which represented, according to Chris, a new fresh start.
Bruce Moon’s work indicated that certain themes emerge with some frequency during adolescent art therapy. I found that several of the themes that Moon mentioned did appear in Chris’ art: self-loathing, intense anger, and identity confusion. The self-loathing appeared in Chris’ devil mask and his “infected” clay log. Chris’ intense anger was illustrated in his clay tableau of chaos and his emotional hurricane. His identity confusion appeared in his super hero robots and the emotional hurricane.

Although this case study only involved one adolescent, it does suggest that art therapy can be an effective modality with a bipolar adolescent. Tailoring the art interventions to a Chris’ interests seemed to be effective. He would always engage in the therapeutic art tasks involving building and sculpture—his big interests. Throughout our time together, Chris would test and re-test my boundaries and my patience. By maintaining consistent and firm boundaries, I was able to create a safe and structured therapeutic holding space for Chris. Within this space, Chris began to relax and freely share about his concerns for the future and frustrations with the present. Creating that safe holding space for Chris also enhanced our therapeutic rapport. According to the literature, adolescents desired structure and support within a therapeutic setting (Martin et al., 2006). Finally, through observing Chris’ art and his artistic process, I began to accurately predict the cycles of Chris’ manic and depressive phases.
I would recommend that if future research were done regarding this topic, a larger sample size be studied in order to get a more accurate understanding of how art therapy might best serve adolescents with bipolar disorder.
References


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**Individual Participation**
- Participant actively engages in group discussions or conversations
- Passive engagement in discussions and activities. Must be drawn out by therapist.
- Initially refused to participate as indicated through verbalization or behavioral noncompliance. But then participates anyway.
- Refused to participate as indicated through verbalization or behavioral noncompliance.

**Art Task Completion**
- Creates art piece and puts a lot of effort and energy into work.
- Creates art piece but puts minimal effort and energy into work.
- Begins to create art piece but stops before completing it.
- Refuses to create art piece.

**Behavior**
- Non disruptive the entire time. Remains in session for entire session. Pays attention to therapist the entire time.
- Mostly non-disruptive behavior, 1 or fewer re-directions from therapist. Remains in room for entire session. Mostly pays attention to therapist the entire time.
- Walks out of therapy room but able to re-enter group again. Only 2+ re-directions from staff. Walks out of room toward end of session/asks to return to cottage toward end of session.
- Walks out of session. Asks to return to cottage within first half hour of session. Disruptive behaviors interrupt session and client sent back to cottage.

**Verbalization**
- No verbal threats made to therapist. Shares personal info with therapist. Gives constructive feedback or insight regarding topic/activity
- Minimal or no verbal threats made to group or staff. Shares some personal info with the therapist. Comments in session remain on topic
- Verbal threats made to the therapist but able to be redirected. And/or shares minimal personal info with the therapist.
- Verbal threats to the therapist causes client to be sent back to cottage.

**Strengths**

**Comments**

Scale:
- 16-13=Strong
- 12-10=Average
- 9-6=Weak
- 6-0= Noncompliant

Grand Total:
Appendix B

Sample Release Form

Authorization for Presentation

I, the undersigned parent or legal guardian, do hereby give my consent for my child,______________________________, to be the subject of a research project for a masters thesis study. I also understand this child’s artwork may be used for educational or research purposes at Ursuline College. I understand that my child’s identity will be protected and that information that would lead to the identification of my child or his/her family will not be revealed. Slides of my child’s artwork will be included in the thesis presentation and a paper based on the presentation may appear in published proceedings or in a professional journal.

Signature of Parent/Legal Guardian____________________________ Date:__________

Signature of Child_________________________________________ Date:__________